**Beth Harp, LPC, NCC**

**Private Practice Informed Consent and Business Policies**

**1701 Gateway Blvd Suite 385**

**Richardson, TX 75080**

**Phone: 972-742-7697**

**Fax: 972-677-7349**

This document contains important information about my private practice and business policies. Please read it carefully and discuss with me if you should have any questions. When you sign this document, it will represent an agreement between us. However, the ‘therapist-client’ relationship does not exist until after the initial assessment is completed & we have both decided to move ahead, as evidenced by your signature on this form.

**CREDENTIALS**: My name is Beth Harp. I am a Licensed Professional Counselor (LPC) and a National Certified Counselor (NCC).

**PSYCHOLOGICAL SERVICES**: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist & the client, & the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work in between sessions on things we talk about during our sessions.

Psychotherapy can have both benefits & risks. Since therapy often involves discussing unpleasant parts of your life, you may experience uncomfortable feelings like sadness, guilt or anger. As you learn more about yourself & begin to make changes, you might encounter increased conflict with friends, co-workers, or family members. On the other hand, therapy has also been shown to have benefits for people who go through it & those benefits can far outweigh any discomfort encountered during the process. Therapy often leads to better relationships, solutions to specific problems, & a significant decrease in distress. But there are no guarantees of what results you will experience.

Our first session(s) will involve an evaluation of your needs. By the end of this process, I will be able to offer you some first impressions of what our work might include & a treatment plan to follow if you decide to continue. I may ask you to complete some additional psychological tests to aide me in your treatment. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, & energy, so you should be careful about the therapist you select. If you have questions about my procedures, we can discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

If there is involvement with any other professional (doctor, therapist, counselor, probation officer, etc.), I may ask you to sign a Release to Exchange Information form that allows me to contact them. You will also complete a questionnaire at the beginning of your therapy. This will help me to provide you the best possible care.

**PROFESSIONAL FEES**: The current full fee for an initial session is $150. Subsequent standard individual sessions (45-50 minutes) are $150.00. All fees can be increased by $10 annually. The fee for longer or shorter sessions is prorated based on the standard session fee. In addition to weekly appointments, I charge the same hourly fee for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. These services are not usually reimbursed by insurance. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, copying your file (30c per page with a $2.00 minimum that must be paid in advance), & the time spent performing any other professional service you may request of me.

**COURT RELATED FEES**: I have no forensic experience and being a master’s level counselor would generally not be considered an expert witness. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involved CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge ***$150.00 an hour*** for preparation and attendance at any legal proceedings. This includes travel and waiting time. Also, a ***$1500.00 retainer***will be required up front if a subpoena is issued or court appearances are requested. If a client is involved in a lawsuit that creates a situation where I am court ordered to be involved I am happy to bill the initiating party for services rendered. If the charges are not paid at the time of services rendered, the fees will become the client’s responsibility.

**BILLING & PAYMENTS**: You will be expected to pay for each session prior to the start of that session, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

You may pay with cash, credit card (VISA, American Express, Discover & MasterCard), or check. If you are unable to pay for a session, the balance must be paid in full the following week or the session may be rescheduled or discontinued. Checks returned for non-sufficient funds (or checks you request to be held to avoid a NSF return) will incur a $30 service fee in addition to fees assessed by my bank. This fee & the value of the check must be paid in cash or by credit card before another session can be scheduled, & checks may then no longer be accepted. When your course of therapy ends, your account must be paid in full. Any outstanding balance upon termination may be turned over to a collection agency. Client hereby consents to delegation of collection services to an outside collection agency, including the release of any information required by that agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. Payments by credit cards will be in accord with the pre-authorization for health care form provided by this office.

**MISSED APPOINTMENTS**: You will be charged for missed appointments & cancellations unless you cancel within no less than 24 hours of the appointment, unless waived on a case by case basis. Work conflicts would not be reasons for this fee being waived. The fee for missed appointments & late cancellations (less than 24 hours’ notice) is my usual & customary fee as described above. In some circumstances, a telephone session may be substituted for face-to-face, if you are not able to make it to the office. You must use a secure telephone line for this option. Frequent cancellations and rescheduling may result in termination and referral and will be discussed in person or by phone before this occurs. With the signature below, you will authorize Beth Harp,LPC to charge credit cards for late cancellation & missed session appointment fees when incurred. Client understands the appointment policies of the office & assumes responsibility for payment of fees related to late cancellations or missed appointments as described above. Such charges are payable immediately & will be automatically charged to your credit card, where applicable, & are not normally reimbursable by insurance.

**INSURANCE**: Although this practice does not bill third-party payers, I will provide you the necessary receipts & information for you to file a reimbursement claim. Please be aware that there is no guarantee that your insurance will cover the service you receive here. I reserve the right to bill for excessive insurance paperwork demands separately after consulting with you. You will be responsible for a fee at the time of service unless we have made other arrangements. Information about out of network payments is available & I will answer any questions you may have about reimbursement from your insurance carrier. Medicare and Medicaid are providers that do NOT cover LPCs.

**EMERGENCIES**: I do not provide formal emergency services. However, I wish to be available as much as reasonably possible. You may call me at any time & leave a message. I may have the time in between clients to return your call, but should I not be able to do so in a timely manner, and you feel that your situation is too urgent to wait, please contact **Timberlawn Hospital at 214-381-7181** or a crisis line. Please use good judgment about the wisdom of waiting for my call versus calling 911 or going to the nearest emergency room for immediate care.

**CONTACTING ME**: I may not be immediately available by phone. Even when in the office, I do not answer the phone if I am with a client. When I am unavailable, the best way to contact me is by text or leaving a voicemail message. If you choose to communicate via e-mail, remember that the internet is not a secure medium for transmitting confidential information. Consequently, I use e-mail communication only in response to your e-mails & with your permission. Also note that ***it is against HIPAA standards for me to contact you electronically using text or email that is not encrypted. And that information exchanged in this manner in NOT protected.*** Knowing this, if you still wish for me to respond to you with either of these methods, please initial here.

 Client’s initials \_\_\_\_

**CONFIDENTIALITY**: In general, the confidentiality of all communications between a client and a therapist is protected (or if the client is a minor by his or her parent or guardian), and I can only release information about our work to others with your written permission. However, there are a number of exceptions including some legal proceedings.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client’s treatment. For example, ***if I believe a child, elderly person or disabled person is being abused or in the case of suspected sexual exploitation by another mental health professional, I must file a report with the appropriate state agency. If I believe that*** ***a client is threatening serious bodily harm to another, I may take protective actions, which could include notifying police. If the client threatens self-harm, I may involve others to ensure the client is protected including your emergency contact person and possibly the local authorities.*** If a similar situation occurs I will attempt to fully discuss it with you before taking any action.

Understand that confidentiality is not the same as statutory privilege. If I receive a legal subpoena or if you’ve given permission for exchange of information for insurance purposes, details regarding our sessions may be disclosed. I will try to make every effort to contact you first should this occur.

**PROFESSIONAL CONSULTATION:** I may communicate with treatment team members in order to better coordinate your care. I may also find it helpful to consult with other professionals about your case. If so, I will not reveal your identity.

**ADDITIONAL EXCEPTIONS:**

**\*\*\* Please note that any individual attending group, joint marriage sessions and/or family sessions has access completely to the records of that session.\*\*\***

**MARRIAGE COUNSELING:** If you are involved in marital counseling, confidentiality does not include your spouse and is left up to my discretion. This will be explained further in your initial session.

**PARENTS OF ADOLESCENTS:** *If the client is a child or adolescent and is engaging in reckless behavior or persistent substance abuse, a need to discuss these activities with their parent will be discussed. The minor will then be given the opportunity to inform their parent/guardian during the counseling session of behaviors that are deemed by me a harm to self*. Please understand that I will not betray confidences of parental defiance or rebellion that are not life threatening. I will make every effort to encourage the minor to be forthright with their guardians as transparency is a recognized dynamic of a healthy relationship. If a parent feels betrayed by my keeping of confidentiality, I encourage the family member to schedule a family session to discuss this matter.

**PARENT CONSULTATIONS**: Also, in counseling involving a minor child as the identified patient, the rights of confidentiality extend to them only. If you share information during a parent consultation that would impact their treatment or if the child is present, realize that either parent has access to the child’s records and anything said by the other parent would not be considered confidential during a family session or parent consultation since they are not a counseling patient.

**LEGAL ISSUES:** If at any time you involve me personally in legal proceedings including but not limited to requesting files for an attorney, having a subpoena issued by an attorney or court, requesting me to give a deposition, or verbally or in writing threatening me in a lawsuit, I will disclose general information to my attorney in order to follow best legal and ethical practices when addressing these issues.

**By initialing here, I am recognizing and agreeing to the exceptions to confidentiality listed above which could pertain to records made at a later date.**

Clients initials \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex & I am not an attorney.

**PROFESSIONAL RECORDS**: The laws & standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Be aware that you will be charged for any professional time spent by my office in responding to information requests.

**COMMITTMENT TO COUNSELING**: A necessary element of the counseling process is your commitment to attend sessions regularly. You may stop the counseling at any time, but please inform me before your last session. Attending sessions under the influence of alcohol or drugs or in possession of a weapon is not allowed.

Your signature below indicates that you have read, understand, & agree to the information in this document.

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Signature of Client or Responsible Party and Date

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Drivers License Number

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Printed name of Client or Responsible Party

**Beth Harp, LPC, NCC**

**Receipt of Notice of Policy and Practices to Protect the Privacy of your Health Information**

I acknowledge that I have been given a copy of ‘Notice of Privacy Practices’

Signature of Client or Responsible Party

Printed Name of Client

Relationship of Personal Representative to Client

 Consent to Method of Contact

Home number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave msg? .Yes .No

Cell/Text Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave msg? .Yes .No

Other Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave msg? .Yes .No

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave msg? .Yes .No

OK to send appointment confirmation via method of contact you have approved above? .Yes .No

OK to send receipts, future updates, and information about Beth Harp’s practice? .Yes .No

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**Credit Card Authorization**

Please complete the following information. This form will be securely stored in your clinical file & may be updated upon request at any time.

In case of late cancellations and/or no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $30 in addition to fees assessed by my bank will be charged for returned checks. In the case of extended telephone consultations, participation in legal proceedings, or other administrative activities you will be charged a fee as specified in my private practice and business policies.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am authorizing Beth Harp, LPC to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment, I do not cancel my appointment at least 24 hours in advance, a check is returned for any reason as agreed to in the office policies stated in the signed “private practice and business policies”, or I have an unpaid balance. I agree I will not dispute those charges (charge back). This form may be updated upon request or as additional credit cards are utilized for rendering payment.

Card Type (circle one): Visa MasterCard American Express Discover

Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security code\_\_\_\_\_\_\_\_

(In filling out “Name as Printed” section you are confirming that you are authorized to use the card of the above named individual.)

Billing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I am authorizing Beth Harp LPC, ATR to charge for scheduled appointments/office fees.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beth Harp, LPC, NCC**

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

THIS NOTICE DESCRIBES HOW COUNSELING AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review it carefully.

1. **Uses and Disclosures for Treatment, payment, and Health Care Operations**

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

- Payment is when we obtain reimbursement for your healthcare. 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 healthcare 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 my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* **“Disclosure”** applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
1. **Uses and Disclosures Requiring Authorization**

We 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 we are asked for information for purposes outside of treatment, payment, and healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. 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) we 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.

1. **Uses and Disclosures with Neither Consent nor Authorization**

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

* + **Child Abuse**: If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth commission, or to any local or state law enforcement agency.
	+ **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
	+ **Health Oversight:** If a complaint is filed against me with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us 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 we 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 it is determined that there is a probability of imminent physical injury by yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to your emergency contact or medical or law enforcement personnel.
	+ **Worker’s compensation:** If you file a worker’s compensation claim, we may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.

1. **Patients’ Rights and Counselor’s Duties:**

**Patients’ 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 being seen at this office. Upon your request, I will send your bills 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.

Your access to PHI may be denied 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 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 2 of this 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.

 **Counselor’s 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 you are notified of such changes, however, I am required to abide by the terms currently in effect.
* If I revise my policies, I will notify you of such revisions.
1. **Complaints:**

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact me at my phone number listed above. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

1. **Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on March 1, 2013.