Forever Hope Counseling & Educational Services, LLC

Stone Oak Location
1162 E. Sonterra Blvd, Ste 130
San Antonio, Texas 78258

Boerne
108 Oak Park
Boerne, TX 78006

# *AGREEMENT AND CONSENT FORM*

***Counseling Expectations:***

Our goal is to partner with our clients in achieving their goals. Clients begin services weekly basis. After your needs are improving, the frequency of your appointments are scheduled on a bi-weekly basis. During the final stages of your treatment or therapy, your sessions will be scheduled to monthly sessions.

***Minors:***

Family or parent sessions are scheduled every **5th** session or as frequently as necessary. A responsible adult must be present to speak to the therapist at the end of each session. Parent sessions are a time to share updates, gain strategies and skills provided by your therapist and it provides a time for you to provide feedback.

**Please inform our office of any changes in child custody.**

***Counseling Services:***

*All payments are due and payable BEFORE your session begins. Your primary payment method on file will be charged unless you inform the office in advance that you prefer to pay by check or cash.*

| | | |
|---|---|---|
| *New Consultation -* | $250 with a Licensed Professional | $150 with a LPC-Associate |
| *Counseling Sessions -* | $140-$150 with a Licensed Professional | $100 with a LPC-Associate |
| | $250 with our Clinical Director | |
| *Crisis Sessions -* | $220-$225 with a Licensed Professional | $150 with a LPC-Associate |
| | $375 with our Clinical Director | |

**We are happy to complete forms or letters for you at the clinician's full rate.**
**Session overages are charged $50 per every 15 minutes.**

There is a **$50 returned check fee** for any payment returned by your bank. ***Initials_____***

***Late Cancellations/Missed appointments:***

We often have many patients who are waiting to be seen by our providers. If a patient does not provide a timely notice that they will not be able to attend their scheduled appointment, we will not have time to schedule another patient that is waiting to be seen. For this reason, our office **requires a 24-hour notice** prior to canceling or rescheduling an appointment.

To avoid a ***full session charge*** for a late cancellation or missed appointment, please contact us 24 hours before the scheduled session. ***Initials_____***

***Psychoeducational Testing:***
$3,300 *(This cost may not be reimbursed by your insurance provider)*

ADHD, Autism Spectrum Disorder, Dyslexia, Learning Disabilities

Testing fee covers 4-6 hours of testing, testing results session, 504 Plan/IEP, advocacy campus visit, & test report with diagnosis (when applicable), along with clinical & educational recommendations.

***Records and Confidentiality:***
Your mental health record is accessible to you within 10 business days of your written request.

A fee of **$45.00** will be charged for the first 25 pages of the record and additional pages will be at a rate of **$1.00 per page**. ***Initials_____***

***Court attendance and testimonies:***
We are not trained custody counselors nor are we expert witnesses.

However, if you chose to engage us in a legal matter, *there is a non-refundable retainer fee of $2,500 due at the time the subpoena is received by FHC*. The retainer is used for a court appearance ($250/hr) to block out time to attend and prepare for your court date - whether we are called on the stand or not or the court case is cancelled.

If the amount of time in court surpasses the single day appearance covered by the prepaid retainer, you will be charged at the agreed upon $250/hourly rate. Additional time spent preparing for ANY attorney's requests including but not limited to: preparing the release of client records, any notarization costs, interviews, responding to ANY attorney's emails or phone calls at the **$250 hourly rate**.

**Additionally, if a subpoena is issued to our company for ANY legal matter, you agree to accept and assume financial responsibility for the payment of the $2,500 retainer fee and your primary payment method will be charged at the time we receive the subpoena.** ***Initials_____***

***Electronic Communication:***
We are committed to providing a safe, nonjudgmental, and confidential therapeutic environment for you and your family. Please be aware that all communication via email, text messages, and other electronic means limit your privacy and will increase the chances of your personal information being shared with others.

OUR CLINICIANS DO NOT COMMUNICATE BY TEXT OR EMAIL. ***Initials_____***

Although our sessions may be very delicate in nature, both emotionally and psychologically, please keep in mind our relationship is professional rather than personal. Please use your best judgement and reserve all calls for times you are unable to wait until your next session.

If you would like to speak with your therapist before your next ***scheduled*** session, please contact the office to set up a telehealth (phone/ZOOM) or in-person session (normal session rate applies). ***Initials*****_____**

***Termination of Services:***

You may choose to end our counseling relationship at any point for any reason. We will be respectful of your decision to end our counseling relationship.

If you **miss/cancel 3 consecutive sessions**, the therapist reserves the right to remove you from their schedule to offer their services to another family. You may be given a referral for a therapist available outside of our practice.

*Thank you for choosing to begin your care at Forever Hope Counseling & Educational Services, LLC….*

_______________________________________________ ______________

**Client Signature / Legal Guardian** **Date**

_______________________________________________ ______________

**Intake Clinician** **Date**

***NOTICE TO CLIENTS***

*The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology.*

*Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.*

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# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a client (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

________________________________________________
Client Signature (Client's Parent/Guardian if under 18)

____________________________
Today's Date

## HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

**Effective date: July 8, 2014**

Forever Hope Counseling & Educational Services, LLC will only release information in accordance with state and federal laws and the ethics of the counseling profession.

This notice describes Forever Hope Counseling & Educational Services, LLC's policies related to the use and disclosure of the client's healthcare information. **Use and disclosure of protected health information for the purposes of providing services.** Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

**TREATMENT:**

- Provide, manage, coordinate care with other healthcare professionals.
  - You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

1. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

2. ***Special Instructions for completing the authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or a psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and are separate the rest of the individual's medical records. Excluded from "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

My signature indicates I understand HIPAA Authorizations and a separate mental health information disclosure form must be signed to grant permission to discuss protected client information.

Client Name: ______________________________________________

Signature:____________________________________________________Date: ______________________

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# Debit/Credit Card Authorization Form

**Forever Hope Counseling requires a credit card on file to secure services with our therapists. Please inform the front desk before your sessions begin if you have a preference to pay with cash or check.**

**Name on the card:** ______________________________________________________

**Type of card:** ____ Visa ______ Mastercard ______ Discover ____ Amex

**Card Number:** _____________________________________________________

**Expiration Date:** _________________ **Security Code:** ___________________

**Billing Address:** ____________________________________________________

**City, State, Zip:** ____________________________________________________

**Phone Number:** ______________________________________________________

**Email address:** ______________________________________________________

**By signing this form, you authorize FOREVER HOPE COUNSELING & EDUCATIONAL SERVICES, LLC to charge this card for clinical, academic, or behavioral services provided for – (client name) ________________________________________.**
*This card will be charged for any fees related to these services such as: missed appointments or same-day cancellations. In the event your card is declined, you agree to offer an alternative credit card or pay cash or check.*

**We are unable to schedule appointments with your therapist if there is a balance on your account.**

Cardholder signature : ________________________________ Date: ____________________

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# Informed Consent for Teletherapy Services

The following information is provided to clients who are seeking Teletherapy services. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss before you agree to sign.

**Teletherapy Services Defined:**

Teletherapy Services means the remote delivering of any form of counseling services via technology-assisted media. This includes a wide array of clinical services and various forms of technology that include, but is not limited to, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video conferencing is the preferred method of service delivery.

**Limitations of Teletherapy Services:**

While Teletherapy Services offer several advantages such as convenience and flexibility, it is an alternative form of therapy, or adjunct to therapy, and thus may involve disadvantages and limitations. *For example, there may be a disruption to the service (e.g. phone gets cut off or video drops).* This can be frustrating and interrupt the normal flow of personal interaction.

Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. *For example, if video quality is lacking for some reason, your counselor might not see various details such as facial expressions. Or if audio quality is lacking, they might not hear differences in your tone of voice that they could easily pick up if you were in their office.*

**Interactive Video, Electronic Medical Record, Secure Email for Documents: *Forever Hope Counseling* uses ZOOM for interactive video, which complies with HIPAA standards requiring 256-bit AES encryption.**

**Client Responsibilities for Teletherapy Services:**

1. The virtual sessions can only be conducted while the client is within the state of TEXAS.
2. The virtual sessions must be conducted on a Wi-Fi or ethernet (not mobile) network for the best connections and to minimize disruption.
3. Only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use “auto-remember” names and passwords.
4. If you conduct a Teletherapy session at your place of employment, make sure you have checkedyour company’s policy before using a work computer for personal communication.
5. As the client, you are responsible for finding a private, quiet location where the sessions may beconducted.
6. Sessions are not able to take place if other individuals are present in your location.
7. Your therapist is required to verify your identity and location at the start of each session.

**In Case of Technology Failure:**

Teletherapy sessions could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. *If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, **PLEASE call the office at (210) 490-9062**.* You must have access to the phone that your therapist has so you can be reached. In addition, your session may need to be rescheduled, if there are problems with connectivity.

**I AGREE TO THE FOLLOWING *(initials)*:**

_______**I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.** I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

_______**I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.**

**Consent for Teletherapy Services Treatment:**

_______**I voluntarily agree to receive online therapy, parent, couples or family therapy services including an assessment, continued care, treatment, and/or other services and furthermore authorize FOREVER HOPE COUNSELING & EDUCATIONAL SERVICES, LLC** 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 withdraw consent for such care, treatment, or services that I receive at any time. By signing this Informed Consent, 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.

_______________________________________________ Date__________________

Patient/Client Signature

_______________________________________________

Parent/Guardian/Legal Representative Signature

(if minor or needed otherwise)

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## ADULT INTAKE FORM

*Please note this information is treated as confidential. It is important that you are as accurate and truthful as possible. Thank you.*

Today's Date:________________________________ Referred by: ____________________________________

Main area(s) of concern: ______________________________________________________________________

Client Name: ____________________________________________________ Age: _____ DOB: __________

Address: ___________________________________________________ Cell #: _________________________

Marital status: ___ Single ___ Divorced ___ Remarried ___ Married ___ Widowed ___Separated

Your Occupation: ___________________________________________ Work #: _______________________

Highest level of education: ___________________________________________________

**Spouse's Information**

Spouse's Name: ____________________________________ Age: ______ Cell #: ______________________

Occupation: ________________________________________________ Work #: ______________________

Address (if different from above): ______________________________________________________________

Highest level of education: ___________________________________________________

Emergency Contact: _________________________________________ Cell #: ________________________

Relationship to client: _______________________________________

May we communicate through email? ___ Yes ___ No

If yes, please list your email: _______________________________________________________

Please list all names and ages of people living in your home:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Are there currently any significant life changes or stressful events that have occurred in the past two years such as: marriage, divorce, new baby, financial instability, domestic violence, moving locations, new job…?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

1. Have you ever received counseling or psychiatric medications? ____ Yes ____ No

Please list any prescription medications (include milligram amount) that you are currently taking:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Previous Diagnosis: ______________________________________________________________

2. Previous therapist's name: _________________________________________________________

3. Previous therapist's phone number: __________________________________________________

4. Prescribing physician's phone and address: ___________________________________________

______________________________________________________________________________

5. Are you currently involved in any pending court cases? ____ Yes ____ No

If **YES**, please specify: _____________________________________________________________

6. Have you ever committed a crime? ____ Yes ____ No

If **YES**, please specify: _____________________________________________________________

7. Have you ever had legal issues such as probation, divorce disputes, etc.? ____ Yes ____ No

If **YES**, please explain: _____________________________________________________________

______________________________________________________________________________

8. Have you ever been physically violent or aggressive with others? ____ Yes ____ No

If **YES**, please specify: ______________________________________________________________

______________________________________________________________________________

9. Do you own any weapons? ____ Yes ____ No

If **YES**, please specify: ______________________________________________________________

10. If you have weapons in the home how do you keep them safe from children?

______________________________________________________________________________

11. How satisfying are your *current* personal relationships?

Least _______ 1 _______ 2 _______ 3 _______ 4 _______ 5 Most

12. How satisfying are your *current* professional relationships?

Least _______ 1 _______ 2 _______ 3 _______ 4 _______ 5 Most

13. How many hours do you usually sleep each night? ______________________

14. How would you describe your eating habits? ____ Poor ____ Good ____ Excellent

15. How much do you exercise per week? ____ None ____ 1-2 hours ____ 3hrs+

16. What are your spiritual or faith beliefs:

__ Christian __ Buddhist __ Muslim __ None ___Other: ____________________

**Biological Family Mental Health History: (Please include yourself and distant relatives)**

| CONDITION | YES | NO |
|---|---|---|
| Alcohol/Substance Abuse | | |
| Anxiety | | |
| Autism | | |
| Depression | | |
| Developmental Delays | | |
| Eating Disorders | | |
| Obsessive Compulsive Disorder | | |
| Schizophrenia, Schizoaffective | | |
| Suicide/suicide attempts | | |
| Odd/Bizarre behaviors | | |
| Other: ____________________________________ | | |

**Wellness & Health**

1. Have you/or the client experience abuse or neglect?

____ physical abuse ____ sexual abuse ____ verbal abuse ____ none

If **YES**, please specify: ______________________________________________________________

2. Do you have any sexual concerns?

___menopause ____andropause ___diminished libido ___ high sex drive ___ painful intercourse

___health issues effecting sex life ___ infidelity ____ other: ____________ ____ none

3. How often do you drink alcohol? ____ never ____ 1-2 a week ____ 3+ times a week

4. Do you smoke? ____ never ____ 1-2 a week ____ 3+ times a week

5. Do you engage in recreational drugs? ____ Yes ____ No

6. Have you ever been hospitalized?

_____ Physical illnesses: ______________________________________________________________

_____ Mental health illnesses: __________________________________________________________

_____ Other reasons: ___________________________________________________________________

7. Have you ever experienced thoughts of hurting yourself or others? _____ Yes _____ No

If **YES**, please specify: ______________________________________________________________

8. Have you experienced suicidal thoughts, plans, or attempts? _____ Yes _____ No

If **YES**, please specify: ______________________________________________________________

9. Have you ever experienced any form of auditory or visual hallucinations? ___ Yes ___ No

If **YES**, please specify: ______________________________________________________________

10. What do you consider to be your strengths? ___________________________________________

________________________________________________________________________________

11. What do you consider to be your areas to improve or develop? _____________________________

________________________________________________________________________________

12. Do you experience fatigue, stomachaches, headaches, or dizziness? __________________________

________________________________________________________________________________

13. Who do you consider your support system in your community or family?

________________________________________________________________________________

________________________________________________________________________________

14. What would you like to gain from therapy or what areas of concern would you like addressed in counseling sessions?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________