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

Forever Hope clinicians attend weekly clinical staff meetings to review, discuss and participate in team collaborations and case conceptualizations to better assist you.

Counseling Expectations:

Our 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:

Parent sessions are considered a form of counseling. These parent sessions are a time to share updates with your therapist and it provides a time for your therapist to provide feedback. Family or parent appointments are scheduled every 5th session or as frequently as necessary. Parents are discouraged from "dropping off their children" for sessions. A responsible adult must be present to speak to the therapist should the therapist need to speak to you. **Please inform our office of any changes in child custody.**

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

Counseling Services:

Consultations -	*$250 (Licensed Professionals)*	*$150 (Associates)*
Counseling Sessions -	*$100 with an Associate*	
	$135 with a Licensed Professional	
	$225 with our Clinical Director	

Crisis sessions are an additional $75 (Licensed Professionals) and an additional $60 (Associates).
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 over the 50-minute session time.
There is a **$50 returned check fee** for any payment returned by your bank. ***Initials*** _____/_____

Educational services:

$225/hr (This advocacy service is provided by our Clinical Director who is a Licensed Professional Counselor Supervisor, Certified School Counselor and Texas Special Education Teacher)

Psychoeducational Testing:

$2500 *(testing charges are subject to change— please call the office for current rates at the time of scheduling for testing)* - **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)

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 retainer fee of $2,500 due at the time the subpoena is received by FHC. This retainer includes travel time for the clinician to drive to the courthouse location. Whether we are called on the stand or not, the retainer is used for a court appearance ($250/hr) to block out time to attend and prepare for your court date.

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.

Clients are responsible for their attorney fees and costs incurred as a result of the legal action. **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 at the time we receive the subpoena. ***Initials_____/_____***

Records and Confidentiality:

Your mental health record is accessible to you upon 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.**

If one member of the couple or one of the parents or guardians request a copy of the record, the other legal guardian or spouse will also be offered a copy of the record at the same cost of $45.00 for the first 25 pages and $1.00 for each additional page. ***Initials_____/_____***

When a request is made directly from a government agency for a record, there is NO charge. ***Initials_____/_____***

Cancellations or Missed Appointments:

We require a 24-hour cancellation notice of your appointment. **You will be charged a FULL rate for any same day cancellation or missed appointment.** Please call us 24 hours prior to your appointment at 210-490-9062 if you need to reschedule or cancel your session. Same day cancellation charges include: absences due to same day illnesses, doctor appointments, vacations, extracurricular activities and other unavoidable obligations. ***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 phone, text or email. 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.

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, you will be removed from the schedule and you will be given a referral for a therapist available outside of our practice.

By signing below, you agree and understand all costs and fees associated with the services we will be providing to you or your family. In addition, you are stating that your questions have been answered to your satisfaction.

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

_____ _____
Client Signature / Legal Guardian Date

_____ _____
Client Signature / Legal Guardian Date

_____ _____
Therapist Signature Date

_____ _____
Clinical Director/Sandra Salazar, NCC, LPC-S Date

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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:

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

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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.
    - o 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 ☐ MC ☐ Discover ☐

**American Express is not accepted*

Card Number _____
Expiration Date _____
Security Code _____
Billing Address _____
City, State, Zip _____

Phone Number _____
E-mail 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

_____. This card will be charged for any fees related to services, such as: missed appointments or same day cancellations. If in the event your credit card is declined, or is not accepted by our credit card system, you agree to use an alternative credit card or to pay by cash or check until we have found a solution to your original preferred bank card.

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.*

Additionally, your therapist's office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Your therapist will take every precaution to ensure technologically secure and environmentally private sessions.

Interactive Video, Electronic Medical Record, Secure Email for Documents: *Forever Hope Counseling* uses JITUZU and or 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 checked your 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 be conducted.
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)

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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CHILD INTAKE FORM

Please provide the following for your child. 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 of concern: _____

Child's Name: _____ Age: _____ DOB: _____

Address (where child lives): _____

Who does the child live with?:
____ mother ___ father ____ both ____step-mother ____ step-father

Do you have the right to bring your child in for counseling? ____ Yes ____ No

PARENT/GUARDIAN INFORMATION:

Name: _____ Cell #: _____

Specify if: ____biological ____ step ____guardian ____adoptive

Occupation: _____ Work #: _____

Address (if different from above): _____

Highest level of education: _____

Name: _____ Cell #: _____

Specify if: ____biological ____ step ____guardian ____adoptive

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:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL BACKGROUND:

Who is your child's Pediatrician?: _____

Date of last visit: _____

Phone Number: _____

Address: _____

1. Has your child ever received any type of mental health services? (psychotherapy, counseling, medication, psychiatric services)? _____ Yes _____ No

If **YES**, please specify: _____

2. Previous therapist's name: _____

3. Previous therapist's phone number: _____

4. Do you feel previous counseling was successful? _____

5. Is your child currently taking any medications? _____ Yes _____ No

If yes, please list medication(s) and milligram(s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

6. About how long has your child been on these medications? _____

7. Prescribing Physician's name & number: _____

8. Does your child complain of pains, stomach aches, headaches, tiredness?: ___ Yes ___ No

If **YES**, please specify: _____

_____

Childhood Illnesses: ___ Yes ___ No Please list: _____

Allergies: Childhood Illnesses: ___ Yes ___ No Please list: _____

Injuries: ___ Yes ___ No Please list: _____

DEVELOPMENTAL MILESTONES: (To the best of your memory, please estimate when your child reached these milestones.)

1. Eating: _____ bottle fed or ___ breast fed
2. Sat up at: _____
3. Sleeping habits: _____
4. Crawled at: _____
5. Walked at: _____
6. Smiled at: _____
7. Used complete sentences: _____
8. Learned to ride a bike: _____

PREGNANCY:

Is this child your: _____ biological child _____ adopted child _____ foster child
Was your child a planned pregnancy? _____ Yes _____ No Weeks of gestation: _____
Natural or C-Section? _____
Please list any delivery complications: _____
_____

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

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

Describe your child's –

Sleep routine: _____

Eating habits: _____

EDUCATION BACKGROUND:

1. What school is your child attending?: _____ Grade: _____

2. Has your child ever had to repeat a grade? ____ Yes ____ No

If **YES**, please specify: _____

3. Has your child ever been suspended or expelled from school? ____ Yes ____ No

If **YES**, please specify: _____

4. Has your child ever been recommended or received special education services?

____ Yes ____ No

a. If yes, which grade(s)?: _____

5. Does your child currently have an IEP or 504 from his/her school? ____ Yes ____ No

6. Describe the main focus of your child's IEP or 504 Plan (note any accommodations your child is currently receiving or **please provide a copy of the IEP/504**):_____

_____

7. Please inform us of your child's schooling history:

School Level	Name of School	Grade(s) Attended
Day Care		
Elementary School		
Middle School		
High School		

PLEASE CHECK ANY OF THE FOLLOWING RELATED SERVICES:

___ IEP ___ 504 ___ SPEECH ___ OT ___ PT

SOCIAL AND PEER DEVELOPMENT SKILLS:

1. Is your child struggling academically or behaviorally in school?: ____ Yes ____ No

If **YES**, please specify: _____

2. On average how long does it take your child to finish homework?: _____

3. Does your child spend time outdoors?: _____

4. How much time does your child spend on electronics in a week? _____ hours.

5. Does your child struggle with limits & boundaries? ____ Yes ____ No

If **YES**, please specify: _____

6. What game ratings do you allow your child to play?: _____

7. Does your child use the internet without supervision?: ____ Yes ____ No

8. What safeguards are you taking regarding explicit exposures to harmful exposures?:

_____

9. What chores and responsibilities does your child have at home? _____

_____

10. How many friends would you say your child has?: _____

11. Does your child have difficulty making friends? ____ Yes ____ No

12. Does your child have difficulty communicating or socializing with others?: _____

_____

13. Is he or she heavily interested in a particular topic or activity?: _____

_____

14. Does your child seem to enjoy things other children their age enjoy?: ____ Yes ____ No

15. Does your child have repetitive behaviors or rituals they focus on daily? __ Yes __ No

If **YES**, please specify: _____

16. Does your child struggle with understanding social cues? ____ Yes ____ No

If **YES**, please specify: _____

16.Has your child ever imposed self-injury? ____ Yes ____ No

If **YES**, please specify: ___ SI ___ HI ___AH ___VH : _____

_____

PARENTING:

1. In a few sentences, please describe your relationship with your child:

_____

_____

_____

2. What are your methods of discipline regarding your child?

___ grounding ___ spanking ___ lectures _ ___ yelling ___take away privileges ____ other

3. Are you open and willing to learn new and effective strategies in handling difficult behaviors?

____ Yes ____ No

4. Has your child ever been cruel to animals? ____ Yes ____ No

6. What is your family's faith or spiritual belief?: _____

6. Would you like prayer to be incorporated in your child's sessions?

____ Yes ____ No ____ I don't know

7. What do you do well as a parent?: _____

_____

8. What do you need help with as a parent?: _____

_____

9. What do you consider to be your child's strengths?: _____

_____

10. What do you consider to be your child's areas of improvement needed?: _____

_____

11. Are there 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 school…?: _____

_____

_____

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

If **YES**, please specify: _____

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

_____

ABUSE:

1. Any experiences of abuse or neglect?: __ physical abuse __ sexual abuse __ verbal abuse

Details: _____

_____

2. What would you your child to gain from therapy or what areas would you like to be addressed in sessions?

Please explain any other details you would like to share: