



Forever Hope Counseling & Educational Services, LLC

Stone Oak Location
1162 E Sonterra Blvd Suite 130
San Antonio, Texas 78258
www.foreverhopecounseling.com

Boerne Location
108 Oak Park
Boerne, TX 78006

COUNSELOR-CLIENT AGREEMENT AND CONSENT FORM

A few words about our counseling center:

Forever Hope Counseling is committed to provide the highest quality of services by using a multidisciplinary treatment approach. We believe every individual has the capability to succeed in improving their quality of life regardless of the nature of their conditions or life experiences. During your initial consultation, our Clinical Director, Sandra Salazar, will assess your needs and will offer clinical recommendations. She will also select a trained therapist on our team who best meets your needs to begin counseling services. In some cases, appropriate diagnostic testing will be recommended to better understand your needs.

It is important for you to know that 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 showing awareness, improvement or positive change, the frequency of your appointments, are scheduled on a bimonthly basis. During the final stages of your treatment or therapy, your sessions will be scheduled to monthly sessions.

Clients, who are ready to end treatment, develop healthy living strategies, learn coping & communication skills and to improve their personal growth. They are active participants learning new ways to manage, resolve, or overcome their difficulties.

Cancelled or Missed Appointments Fees:

We require a **24-hour cancellation notice of your appointment regardless of the reason for your absence.** You will be charged a FULL rate for any same day cancellation or missed appointment. Messages can be left on our voicemail 24 hours prior to your appointment at 210-490-9062. Same day cancellation charges include: absences due to same day illnesses, doctor appointments, vacations, extracurricular activities and other unavoidable obligations. **Initials** ____/____

There is a **\$50 returned check fee** for any payment returned by your bank. **Initials** ____/____

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. Typically, these family or parent appointments are scheduled every 5th session or as frequently as necessary. Parents are expected to attend these sessions to gain parental strategies and provide insight to their child's therapist. Parents are not allowed to "drop off their children". A responsible adult must be present to speak to the therapist should the therapist need to speak to you. **You must inform our office of any changes in child custody for the child/children related to our counseling services.**



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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:

New Consultations – \$185 (Licensed Professionals) \$100 (Interns)

Counseling Sessions – \$125-\$185 (Licensed Professionals). \$90 (Interns)

We charge full rates for our clinicians to complete forms or letters for you.

Session overages are charged \$50 per every 15 minutes over the 50 minute session time.

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:

\$1895 - ADHD, Autism Spectrum Disorder, Dyslexia, Learning Disabilities

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

Court attendance and testimonies:

There is an **\$800 retainer fee** for all court appearances. If the amount of time in court surpasses the prepaid retainer, you will be charged at the agreed upon \$200/hour rate.

Additionally, if a subpoena is issued to your therapist for ANY legal matter related to you or your family member, you agree to accept and assume financial responsibility for the time 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 as well as phone calls at the \$200 hourly rate.* **Initials** _____/_____

Records and Confidentiality:

Your mental health record is accessible to you upon request. In some instances, one parent or one individual in couple's counseling may request a copy of the family/couple's records. **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.** When one member of the couple or one of the parents requests a copy of the record, the other parent/individual in couple's counseling will also be offered a copy of the record at an additional cost of \$45.00 for the first 25 pages and \$1.00 for each additional page. This does not include postage and handling. You will be given a receipt after each session or payment for your records. When a request is made directly from a government agency or official, there is NO charge. **Initials** _____/_____



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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 are NOT permitted to communicate by phone, text or email. Please leave a message for your therapist with our front desk or call to schedule a phone session. Although our sessions may be very delicate in nature, both emotionally and psychologically, please keep in mind our relationship is professional rather than personal. All contact between you and your therapist will be limited to paid sessions.

Please use your best judgment 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 3 consecutive sessions, your future appointments will be cancelled and you may be given a referral for a transfer to another therapist outside of our practice. Our clients share the responsibility for their treatment and are committed to attending their sessions consistently.

By signing below, you understand in the event that a request for your mental health records has been subpoenaed or made by either you or your spouse or significant other that is participating in counseling with you, you agree that an original copy of the records will be released and a copy of what was released will be sent to you and your spouse/partner by mail. You are also saying that you 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(s) | Date |
| _____ | _____ |
| Client Signature(s) | Date |
| _____ | _____ |
| Therapist Signature(s) | 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.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times or service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

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 HEALTH 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; however, you must still provide a credit card for your file.

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 these 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 offer 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 Doxy.me 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.



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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:

_____ 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 of concern: _____

Name: _____ Age: _____ DOB: _____

Address: _____

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

Employment History

Your Occupation: _____ Cell #: _____

Spouse's Name: _____ Age: _____

Spouse's Occupation: _____ Cell #: _____

May we communicate through email? ___ Yes ___ No

If yes, please list your email: _____

Emergency Contact: _____ Cell #: _____

Relationship to client: _____

Highest level of education: _____

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...? _____



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Please list any prescription medications that you are currently taking: _____

Previous Diagnosis: _____

1. Have you ever received counseling or psychiatric medications? ____ Yes ____ No
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?
If YES, please specify: _____
6. Have you ever committed a crime?
If YES, please specify: _____
7. Have you ever had legal issues such as probation, divorce disputes, etc.?
If YES, please explain: _____

8. Have you ever been physically violent or aggressive with others?
If YES, please specify: _____
9. Do you own any weapons?
If YES, please specify: _____
10. How satisfying are your current personal relationships?
Least ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 Most
11. How satisfying are your current professional relationships?
Least ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 Most
12. How many hours do you usually sleep each night? _____
13. How would you describe your eating habits? ____ Poor ____ Good ____ Excellent
14. How much do you exercise per week? ____ None ____ 1-2 hours ____ 3hrs+



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15. What are your spiritual or faith beliefs: ___ Christian ___ Buddhist ___ Muslim ___ None
Other: _____

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

| Condition | Please check | |
|--------------------------------|--------------------------|--------------------------|
| Alcohol/Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Developmental Delays | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Obsessive Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Schizophrenia, Schizoaffective | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicide/suicide attempts | <input type="checkbox"/> | <input type="checkbox"/> |
| Odd/Bizarre behaviors | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

Wellness & Health

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

___ physical abuse ___ sexual abuse ___ verbal abuse

2. Do you have any sexual concerns? ___ menopause ___ andropause ___ diminished libido
___ high sex drive ___ painful intercourse ___ health issues effecting sex life ___ infidelity
___ other: _____

3. How often do you drink alcohol? ___ never ___ 1-2 a week ___ 3 or more times a week

4. Do you smoke? ___ never ___ 1-2 a week ___ 3 or more 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: _____



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6. Have you ever experienced thoughts of hurting yourself or others? _____

7. Have you experienced suicidal thoughts, plans, or attempts? _____

8. Have you ever experienced any form of auditory or visual hallucinations? _____

9. What do you consider to be your strengths? _____

10. What do you consider to be your areas to improve or develop? _____

11. Do you experience fatigue, stomachaches, headaches, or dizziness?

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

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



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This page is to be completed by the clinician during initial consultation.

Recommendations:

| | | | | |
|------------|-------------------|---------------------------------------|------------|-------------------------|
| Frequency: | Weekly | Biweekly | Triweekly | Consult Only |
| Type: | ABA | Skills Training | Counseling | Diagnostic Testing |
| Level: | LPC / LMFT / LCDC | LPC-Intern/LMFT-Associate/PsyD Intern | | PhD / Clinical Director |

Other comments:

Accepted _____ Denied _____ Referred to: _____

Recommended Goals:

1. _____
2. _____
3. _____

Special Notes:

Recommended Clinician: _____

Meet & Greet date and time: _____

Date and time requested: _____

Rate: _____

Signature

Date