Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices (HIPPA NOTICE) from COUNSELING LAS CRUCES, LLC. The Notice of Privacy Practices (HIPPA NOTICE) provides information about how we may use and disclose your protected information. We encourage you to review it carefully.

I acknowledge receipt of the Notice of Privacy Practices from (HIPPA NOTICE) COUNSELING LAS CRUCES, LLC.

Signature: _____ Date: _____
(Client / Parent / Guardian)

COUNSELING LAS CRUCES, LLC
133 WYATT DRIVE SUITE #3
LAS CRUCES, NM 88005
PH: 575-526-9878 FAX: 575-526-7835

COUNSELING LAS CRUCES, LLC
133 Wyatt Drive Suite 3
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COUNSELOR-PATIENT SERVICES AGREEMENT

Welcome to our practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems you are experiencing. 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 on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. 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, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should 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.

As a licensed mental health counselor, I am supervised and may consult my supervisor regarding your care.

APPOINTMENTS

I normally conduct an evaluation that will last from 2 to 4 sessions. I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay your portion unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. **We do not make reminder calls about appointments.** It is important to note that insurance companies do not provide reimbursement for cancelled or missed appointments. **My policy is to charge patients the amount that the insurance company combined with their copayment would be for same-day cancellations and missed appointments.**

PROFESSIONAL FEES

My hourly fee is $80.00, and can be negotiated on a case-by-case basis. If you become involved in legal proceedings that require my participation, (even if another party calls me to testify) my forensic charges are $150.00 per hour. Because of the difficulty of legal involvement, I charge $150.00 per hour for preparation and attendance at any legal proceeding.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by my office staff or an answering service who can reach me at all times. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the counselor or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a counselor. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information).

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the counselor-patient privilege law. I cannot provide any information without your (or your personal or legally-appointed representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon either party's appropriate request, release all of the information in my records *directly related* to any injuries or disabilities claimed by the patient for which he/she is receiving benefits from his or her employer, upon either party's written request. Information in the records that is not directly related such injuries or disabilities may only be released with a signed authorization from the patient.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I know or have reasonable suspicion to believe that a child under 18 is an abused or a neglected child, the law requires that I immediately report the matter to an appropriate governmental agency, usually the office of the Department of Child, Youth and Family Services in the county where the child resides. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited, I must immediately report that information to the Department of Child, Youth and Family Services. Once such a report is filed, I may be required to provide additional information.

- If I believe that the patient presents a substantial and imminent risk of serious harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

- If a patient threatens a substantial risk or serious harm to himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection

THE PATRIOT ACT

The "Patriot Act," known legally as "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act," was passed by the Congress with little debate on October 21, 2001, only six weeks after the September 11 attacks on the World Trade Center and the Pentagon. Of particular concern to professional psychotherapists are two sections of Title II of the Act: "Enhanced Surveillance Procedures" (Mansdorfer, 2004). The Act, which was due to sunset in 2005, was reauthorized by the U.S. Congress and signed by President Bush in March 2006.

I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I cannot reveal when we have disclosed such information to the government.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

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 may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. Please allow a reasonable amount of time for copying your records.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients over the age of 14 have the right to consent to and receive individual psychotherapy and information about that treatment cannot be disclosed to anyone without the child's agreement. Parents have the right to review the records of children under 14 unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child patient between 14 and 18 and his/her parents, allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern. Before giving parents other information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Appointment Cancellation Policy Agreement:

Counseling Las Cruces, LLC is committed to providing all our clients with exceptional care. When our clients cancel without giving our office enough notice, it prevents other clients from being seen.

Please give us a call at (575) 526-9878 to give 24-hour notice to notify us of any changes or cancellations prior to your scheduled appointment. To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.

If prior notification is not given, you will be charged a full fee for missed appointments.

Thank you for your understanding and cooperation.

Please sign below to consent to these terms.

X_____

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

_____

Date

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