Jones Counseling & Consulting Inc.
White Stone Building
26205 Oak Ridge Drive
Spring TX 77380
281-241-6550

INSTRUCTIONS

Thank you for selecting Susan C. Jones, M.A., LMFT-S, CRC of Jones Counseling & Consulting, Inc. to provide your counseling services. I will do my best to assist you in making this experience meaningful.

Please read all of the pages thoroughly and let me know if you have any questions regarding its contents.

PLEASE NOTE: **Complete all the information on page on the following pages. Also signatures are required on pages 2, 3, 7 and 10.**

CLIENT REGISTRATION

Today's Date: _____

Client Name_____ Date of Birth_____ Age_____

Address_____ _____

City/State/Zip_____

SSN _____ DL_____

Employer/School Name _____

Address_____

Home Phone #_____Work # _____Cell # _____

In an Emergency, please contact:

Name _____ Relationship _____

Phone # _____

May we leave a message at the following (please circle yes or no)
Home: Yes or No **Work:** Yes or No **Cell:** Yes or No

Unencrypted email address: Yes or No

Email address: _____

*****Please do not cancel appointments by email. You must call the office directly at 281-241-6550*****

If you would like to use an address other than your home address for billing and correspondence, please provide that here:

Other_____

HOW DID YOU HEAR ABOUT ME?

(__) Church_____ (__) Friend (__) Spouse (__) Yellow Pages (__) Relative (__) Internet

(__) Seminar (__) Work (__) Brochure (__) Minister (__) Other _____

ACKNOWLEDGEMENT

I have been provided a copy of

1. **Informed Consent for Treatment**
2. **Electronic Policy**
3. **Financial Responsibility**
4. **Notice of Policies and Practices to Protect the Privacy of Your Healthcare Information**

Susan C. Jones, MA LMFT-S, CRC is hereby granted consent to contact me as specified and for the use and disclosure of my health information as described in those policies for Treatment, Financial, and Health Care Operations.

_____ _____

Client or Authorized Representative Signature **Date**

_____

Printed Name

CONSENT FOR TREATMENT

Client Name_____ **Date of Birth**_____

I hereby voluntarily consent to mental health counseling by my counselor. I have relied on my counselor for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____

Authorized Signature **Date**

MINOR CONSENT

As a parent, guardian or managing conservator, I authorize treatment for the below named child. When applicable I have provided the divorce decree or appropriate documentation:

_____

Name of Minor

_____ _____

Parent, Guardian, or Managing Conservator **Date**

CREDIT CARD INFORMATION (This information will not be stored electronically)

Name as it appears on card_____

Address_____

Relationship_____ **Phone**_____

Credit Card Type :(circle one) MasterCard Visa

Credit Card #: _____ CV Code: _____

Exp. Date: _____

_____

Authorized Signature

INFORMED CONSENT FOR TREATMENT

I am honored that you have chosen me to assist you in your personal growth.

I am committed to providing quality services to my clients and the information necessary to be informed about the treatment process. *If you have any questions regarding anything on this form, please discuss them with your counselor before signing.*

PHILOSOPHY

Mrs. Jones' professional practice extends over 30 years in counseling, supervision and consultation. She sees people from diverse ethnic, racial, socioeconomic and religious backgrounds. Susan is a warm, engaging counselor and seeks to understand the whole person: physical, psychological, relational and spiritual.

EDUCATION

- Master of Arts in Rehabilitation Counseling; The University of Texas at Austin
- Bachelor of Arts in Psychology and Rehabilitation Counseling

ABOUT MRS. JONES

Susan was married for 24 years and is the proud mother of a daughter and grandmother of two grandchildren.
She is surrounded with great supportive friends and family.
She loves music reading, exercise and travel.

CREDENTIALS

LMFT-S (Licensed Marriage and Family Therapist and Supervisor in Texas)
CRC (Certified Rehabilitation Counselor)

COUNSELING

The relationship that exists between a counselor and a client is professional rather than social. Therefore, contact with your counselor will only take place in the provision of a professional service.

Counseling is an opportunity for healing and personal growth. We believe that individuals can possess the ability to do what is necessary to take an active role in this process. The length of time needed for counseling and the amount of intervention required varies with each individual. In order to receive the maximum benefits of counseling, *your regular attendance and participation is imperative*. In most cases, counseling is completely voluntary and you can discuss ending your counseling relationship at any time. However, I recommend that, when possible, all counseling relationships be ended in an appropriate and therapeutic manner, generally requiring a final session to allow for closure. During the counseling process your counselor may recommend books for you to read, offer handouts, or use techniques to facilitate personal growth. We encourage you to discuss with your counselor any approach, technique, or practice with which you have questions, concerns, or need clarification. Counseling can be a difficult experience for some people. The disclosure of past hurts or current struggles can cause a temporary increase in depressive or anxious symptoms. If this occurs for you, please discuss the symptoms with me.

CONFIDENTIALITY

Confidentiality is described as keeping private the information shared between a client and his/her counselor. Counseling sessions here are strictly confidential. Information regarding your counseling sessions will not be discussed, without your permission. ***Please refer to the Notice of Privacy Practice that details under what circumstances confidentiality is limited.***

Participants who are in couples and/or family counseling and are or become involved in individual counseling will have discretion over their own information becoming part of a counseling session involving other family members. Individuals involved in group counseling are required to maintain the confidentiality of the other group members outside of the group sessions.

CONSENT TO DISCLOSE INFORMATION

At times, your counselor may need to consult with other professionals or agencies on your behalf. Your signed consent to disclose information to other agencies and/or individuals will be required. Exceptions may include a subpoena by the court of law. If you have received or are currently receiving mental health services and/or psychotropic medications from another health care provider, we may request your consent to speak with those professionals and/or obtain copies of previous treatment records. Providing treatment may depend on our ability to communicate with these professionals.

Please read the entire Notice of Privacy Practice (pages 7 and 8) relating to protected health care information and records and the Health Insurance Portability &Accountability Act (HIPAA) law of 1996.

APPOINTMENTS

Counseling Services are by appointment only. You are responsible for keeping your appointments and arriving on time. We retain the right to discontinue services if you have missed more than two consecutive appointments, if you do not pay your counseling fees in a timely manner, if you continually refuse to comply with treatment recommendations, if it is clear that you are receiving no benefits from counseling, if you exhibit abusive behavior, if you engage in criminal behavior on the premises, or if you knowingly violate the confidentiality. *We cannot allow unattended minors in the waiting room.* If you do not have child care arranged, please call to reschedule your appointment.

COMMUNICATION AND EMERGENCY SERVICES

You can reach your counselor by calling the office number. If your counselor is unavailable, or you have called after hours, you can leave a message. Your call will be returned at your counselor's earliest convenience. *If you are in crisis and it is after hours, please call 911 or your nearest emergency room. You can also call the Tri-County 24 Hour Crisis Line: 1-800-659-6994.*

ELECTRONIC COMMUNICATIONS POLICY

EMAIL

Though email is quick and very convenient, we can never guarantee your confidentiality when using email. We do NOT conduct therapy over email. If you have an issue or problem you would like to discuss, please let us know by calling our office. If your counselor/therapist is not available, you can leave a message with our administrative assistant or leave a confidential voicemail. We are happy to hear your concerns or experience.

TEXT MESSAGING

Text messaging is a very impersonal and unsecure mode of communication. I can never guarantee your confidentiality when using text messaging. I do not provide any other information in this format. Please do NOT use text messaging to cancel or confirm appointments. I will not reply to any text message and I do NOT conduct therapy over text message.

SOCIAL MEDIA AND WEB SEARCHES

I do not communicate with or contact any of our clients through social media platforms like Twitter or Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

If you have an online presence, there is a possibility that you may encounter one of us by accident. If that occurs, please discuss it with us during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy. I understand that you might choose to gather more information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion, please discuss this with me during our time together so that we can deal with it and its potential impacts on your treatment.

FINANCIAL POLICY

YOUR RESPONSIBILITY

You are financially responsible for the services I provide to you. I will provide a fee ticket or superbill so that you may file for direct reimbursement from your insurance company. I am considered out of network for all insurance plans.

PRIOR BALANCE

Clients with a prior balance at the time services are requested will be asked to pay the prior balance in full before being seen. If the balance cannot be paid then you must make payment arrangements prior to your appointment.

METHODS OF PAYMENT

I accept cash, check, VISA, Master Card, American Express, and Discover

RETURNED CHECKS

There will be a $25.00 fee assessed per check for any and all checks returned from the bank for any reason.

MISSED APPOINTMENTS AND NO SHOWS

I see patients on an appointment basis and request that you call in advance so we can reserve time for you. We make every effort to honor all commitments and request that you extend the same courtesy to us by calling 48 hours in advance if you are unable to keep your appointment. **PLEASE CALL THE OFFICE TO CANCEL APPOINTMENTS. EMAIL IS NOT MONITORED FOR CANCELLATIONS.** You will be charged the full counselor fee for late cancellation, as I often cannot fill your allotted time.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced, the parent that accompanies the minor is responsible for the payments, regardless of the custodial agreement.

INFORMATION CHANGE
Please advise me of any address or phone number changes promptly.

CREDIT CARD INFORMATION
For auto charges we will maintain your credit card information in your file, but is not stored electronically.

FEE SCHEDULE
Therapy sessions are for 55 minutes at the rate of $150. Fees are reviewed annually and are subject to change without notice.

LEGAL TESTIMONY
Please be advised that your counselor/therapist does not provide consultation, evaluation or legal expert testimony. I will assist you with a referral if you need these services. *However,* should your counselor/therapist opinion be so ordered, fees will be charged at the rate of ***$300.00 per hour, portal to portal*** (meaning this includes, but not limited to, all time involved for preparation, parking, mileage, travel time to and from court**,** and all other expenses involved in testifying). This fee will apply as well to depositions or interrogatories. Records review, consultation with clients, litigants, attorneys (in person or via phone or by email); reports; waiting at court, or any other service provided will be charged at the rate of ***$175 per hour or prorated accordingly. These fees are payable in advance.***

MISCELLANEOUS
Charges for other professional services are prorated on the basis of your counselor's per hour fee in 15 minute increments. These services include, but are not limited to phone calls, third-party consultations and correspondence. Off-site consultation is prorated at the counselor's per hour rate.

I have read and understand the financial policy and fee schedule and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time without prior notice.

_____ _____
Signature **Date**

_____
Printed Name

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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Susan C. Jones, MA, LMFT-S, CRC may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes with your *general consent.* To help clarify these terms, here are some definitions.

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or mange your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider such as your family physician or mental health professional.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities such as utilizing information that identifies you.
- *"Disclosure"* applies to activities such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

1. Client's Rights:

- *Right to Request Restrictions*-You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy*-You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny you access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend*-You have the right to an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an accounting*-You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorizations (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

2. Our Professional Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your record, or have other concerns about your privacy rights, you may contact your therapist at 936-202-9503.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Susan C. Jones 10655 Six Pines Drive, Suite150 The Woodlands, TX 77380.

You may also send a written complaint to Texas Department of State Health Services:

Investigations
P.O. Box 141369
Austin, Texas 78714-1369 or call 1-800-942-5540

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on June 15, 2018. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. You may request a personal copy at any time.

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral healthcare providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by providing a written revocation request.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request.

Susan C. Jones, M.A., LMFT-S, CRC is authorized to release protected health information related to the evaluation & treatment of:

_____ _____

Name of Client Date of Birth

Primary Care Physician/Pediatrician Name: _____

Phone: _____

Address: _____

Other Mental/Behavioral Health Provider

Name: _____

Phone: _____

Address: _____

Disclosure may include the following verbal or written information: (check all that apply)

___ Face Sheet ___ History & Physical ___ Laboratory/diagnostic testing results ___ School information
___ Discharge Summary ___ Medication records ___ Psychological eval/testing results ___ Psychosocial assessment
___ ER record report ___ Psychiatric evaluation ___ Behavioral health/psychological consult notes ___ Other
___ Substance abuse treatment record ___ Summary of treatment records & contact dates ___ All records

___ I hereby refuse to give authorization for any release of information

_____

Signature of Patient, Parent, Guardian or Authorized Representative Date

(If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law, i.e. Power of Attorney, Living Will, or Guardianship papers etc.)