CounselSmith Cottage
Pamela Smith McSpadden, MA, LPC
1914 Paradise Street, Vernon, TX 76384
ph: 940-553-1631, 940-839-7352 fax: 940 553-1105
psmcspaddenlpc@counselingcottage.com
www.counselingcottage.com

GENERAL INFORMATION

Date_____

Name _____ Birth Date_____
Month Day Year

Male/Female (circle one) Parent (if minor child) _____

Address _____
Street City/State Zip Code

Phone(Home) _____ (Work) _____ (Cell)_____

Text reminders ok? _____yes ____no e-mail _____

Employer _____

Family Size _____ Married_____ Single_____ Divorced_____ Widowed_____

Insurance
(Please present card for photocopying)

Medicaid Yes _____ No _____

Name of Insured_____ Insured Date of Birth _____

Ins. CompanyName_____Policy Number_____

Group Number_____ CoPay_____

Address_____Phone_____

2nd Insurance?_____Policy Number_____

Medications

Names:_____

Physicians_____

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INSURANCE AUTHORIZATION AND ASSIGNMENT (please, read and sign)
I hereby authorize the provider to release any information acquired in the course of my examination or treatment to my insurance carrier, and I hereby assign to the provider all payments for medical services rendered to myself. I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days if no response is received, I understand that I will be responsible for any charges. I understand that I am responsible for payment of any amount that is not covered by insurance.

Assignment of Insurance Benefits:
The undersigned hereby authorizes the insurance carrier, or any Insurance carrier represented as contractually responsible for payment in whole or part of the patients healthcare bill, to pay directly to the provider responsible for my care, benefits payable to me.

I agree that, should the amount be insufficient to cover the provider's charges, I will be responsible for payment of the difference and that if the nature of the disability be such that it is not covered by the policy, I will be responsible for payment of the entire bill, unless contractual agreements have been made between the provider and the insurance company which negate that responsibility.

_____ _____
Signature Date

Consent for Purposes of Treatment, Payment, and Behavioral Healthcare
I consent to the use or disclosure of my protected health information by Pamela Smith McSpadden, MA, LPC for the purpose of diagnosing or providing treatment to me and obtaining payment for my healthcare bills. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed for treatment, payment or healthcare operations of the practice. Pamela Smith McSpadden, MA, LPC is required to agree to the restrictions that I may request. However, if Pamela Smith McSpadden, MA, LPC agrees to a restriction that I request, the restriction is binding by Pamela Smith McSpadden, MA, LPC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pamela Smith McSpadden, MA, LPC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another healthcare provider, a health plan, my employer, or healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

NOTICE TO CLIENTS: Information in your records that you have or may have a communicable disease made confidential by law and cannot be released without your permission except in limited circumstances including releasing to person who have had risk exposures, release pursuant to an order of the court, or the Department of Health, release health care providers or for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you can be identified unless release of that identifying information is authorized by you, by order of the court or the Department of Health or by law.

Pamela Smith McSpadden, MA, LPC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performances of healthcare operations of Pamela Smith McSpadden, MA, LPC The Notice of Privacy Practices is posted on the CounselSmith Cottage website and in the waiting area of the office.

Pamela Smith McSpadden, MA, LPC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revision be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature Date

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Informed Consent

Client-Counselor Service Agreement

Welcome to Pamela Smith McSpadden, MA, LPC at CounselSmith Cottage. This document 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 federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments

Appointments will ordinarily be 45-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay a $25 cancellation fee [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make ever effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions.

Record Keeping

Your counselor may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7

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years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

Professional Fees
You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash or credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.
If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.
Fees are non-negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at counselor's discretion.
Fee Schedule
psychiatric diagnostic evaluation (Intake) – $145
psychotherapy 45 minutes – $95
psychotherapy 60 minutes – $120
Couples Therapy – 50 minutes - $100
group therapy 45 to 90 minutes – $ 30-$60

Sliding Scale

45 minute individual session

$30,000 (Yearly) and below	$55 initial session	$50

CounselSmith Cottage reserves the right to change fees .

Insurance: If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.
You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.
In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient (co-pay). Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.
If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting Me
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.
Email
Counselor may request client's email address or cell number. Client has the right to refuse to divulge email address. Counselor may use email addresses or text messages to periodically check in with clients or send appointment reminders. Counselor may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. Counselor also has a website (www.counselingcottage.com) and if this is appropriate for the client, counselor may send information through email or text about viewing the website for information related to mental health and wellness. If you would like to receive any correspondence through email, please write your email address here _____.
If you would like to opt out of email correspondence, please check here _____ .
If you would like to opt out of text reminders, please check here _____.
Consent to Counseling
Your signature below indicates that you have read this Agreement and agree to its terms.

_____ _____
Client Signature Date

CSC

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TEXAS NOTICE FORM (HIPAA)
Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH 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:
Pamela Smith McSpadden, MA, LPC may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your 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 manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another mental health provider. - 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 my 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 within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, 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 counseling / therapy notes. "Counseling / therapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. 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.

- Adult and Domestic Abuse: 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.

- Health Oversight: If a complaint is filed against any of our therapists with the State Board of Examiners of Licensed Professional Counselors, Licensed Marriage and Family Therapists, or Licensed Social Workers, the respective Boards have the authority to subpoena confidential mental health information from us 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. Patient's Rights and Mental Health Provider's Duties-

Patient's Rights:

- Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information 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 seeing a therapist. Upon your written request, we will send your bills 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 our 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 your 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. Section 611.008 of the Texas Health and Safety Code allows for up to 15 days for our office to copy, print or otherwise make the requested information available to you.
- Right to Amend – You have the right to request 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 authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Mental Health Provider 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 revised copy in the office and provide you with a copy upon request.

V. Complaints
If you are concerned that any therapist at CounselSmith Cottage has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Texas State Board of Examiners of Licensed Professional Counselors,

Complaints Management and Investigative Section P.O. Box 141369
Austin, Texas 78714-1369
or
by calling 1.800.942.5540.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date-This notice will go into effect on January 1, 2016.

I have been given the opportunity to receive a copy of this document as well as read it.

_____ _____
Patient/Legal Guardian Date

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AUTHORIZATION FOR RELEASE/OBTAINING INFORMATION

I, _____, _____ _____
Name date of birth Social Security Number

Authorize _____ To Disclose to _____

The following information from my records:

_____Initial Assessment/social history
_____Psychiatric/medical history
_____Psycological
_____Educational
_____ Medication Prescribed
_____Vocational
_____School Records
_____Other Specified:_____

****

THIS AUTHORIZATION EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE NOTED. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. I FURTHER WAIVE AND RELEASE PAMELA SMITH MCSPADDEN FROM LIABILITY RESULTING IN THE RELEASE/OBTAINING OF THE ABOVE INFORMATION.

_____ _____
Signature of Client/Guardian Date

_____ _____
Signature of Counselor Date

****

Notice to Recipients of Information: This information has been disclosed to you from records whose condientiality is protected by federal law. Federal regulations (42,CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict ay use of the information to criminally investigate or prosecute any alcohol or drug abuse client /patient.

Date Released_____ Released by_____