

NEW CLIENT PACKET

Thank you for choosing **Elledge Counseling Associates** for your counseling needs. The following pages contain:

- Information on fees and counselor experience
- Intake and policy forms
- HIPPA forms
- Addresses and tips on finding the counseling offices

Please fill out and/or sign the following forms consent/policy forms (if coming as a couple then complete one set for each individual adult client) and bring them with you to your first appointment.

Please also print out a copy to save for your own records.

If you have any questions, prior to your appointment, please feel free to call your assigned counselor. Your counselor will also review the forms with you and answer any questions you have at your first appointment.

Again, thank you for choosing **Elledge Counseling Associates**. We look forward to meeting with you soon.

FEE SCALE AND COUNSELOR EXPERIENCE

Fee Scale

The fees for a 45-minute counseling session range in price from \$25-\$100 and are based on each counselor's education, training, experience, and office location.

Counselor Experience

Licensed Professional Counselor (LPC) - an individual in the state of Texas who has completed a master's degree in psychology or counseling, passed the state exam, and completed 3,000 postgraduate hours of supervised counseling experience with clients.

Licensed Professional Counselor Intern (LPC Intern) – an individual in the state of Texas who has completed a master's degree in counseling or psychology, passed the state exam, and is currently working on the required 3,000 postgraduate hours of counseling experience with clients.

Graduate Student – an individual who is at the end of their master's degree program in counseling or psychology and is working on the required hours of supervised counseling experience to complete their graduate degree. They are under the direct supervision of their university professor and the director of ECA.

INFORMED CONSENT AND PRACTICE POLICIES

I agree to take part in treatment with an **Elledge Counseling Associates (ECA)** counselor. I understand that developing a treatment plan with my counselor and working toward those goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I am also aware that many times clients may feel like stopping therapy due to the pain or discomfort of addressing issues that are important to their well-being. Therefore, I agree to talk with my counselor if I feel like ending therapy before all my treatment goals are met.

Sessions last for 45 minutes. I understand that if I am late to an appointment the counselor will not run over into another client's appointment and I will be billed for the entire session fee.

I understand that no unsupervised minor children are allowed in the building during sessions. If I am unable to find childcare I agree to cancel my session 24 hours before the appointment to avoid a late cancellation fee.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which surpass the confidentiality of the client-therapist relationship and the therapist may be ethically bound and legally required to inform the proper authorities.

Exceptions to Confidentiality:

1. The therapist assesses that the client is a danger to self or others.
2. A client reports past or present abuse/neglect/exploitation of a child, elderly person, or mentally challenged person.
3. A client acknowledges committing present or past abuse/neglect/exploitation of a child, elderly person, or mentally challenged person.
4. When counseling records are subpoenaed by a court of law.
5. A client shares with the counselor their use of pornography involving minors.

If I or my insurance company requests diagnosis information, treatment summaries or session attendance documentation on my behalf, I agree to pay my counselor's regular session fee per hour to research, copy and or complete requested materials. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented. There is *no charge* for providing you with a standard receipt of sessions attended for insurance reimbursement.

By signing below, you are stating that you have read and understood this informed consent and policy statement and have had any questions about this document answered to your satisfaction.

Client Printed Name _____ Date _____

Client Signature _____

REQUEST TO PARTICIPATE IN COURT PROCEEDINGS

If I or my legal counsel requests or subpoenas any counselor from ECA to appear on my behalf, in a deposition or in court, I agree to pay that counselor for his or her time and expenses. Billable time will be compensated at the counselor's regular session fee rate per hour.

Billable time and expenses include:

1. Time spent by the counselor reviewing the case files and preparing for court testimony.
2. The drive time to and from the counseling office and the place of testimony.
3. Time spent waiting for their court appearance and testimony.
4. Any tolls, hotel or meal costs associated with the court appearance.

If I or my legal counsel requests or subpoenas treatment summaries or session attendance documentation on my behalf, I agree to pay my counselor's regular session fee per hour to research, copy and or complete requested materials. This includes information for all legal, disability or insurance purposes. Clients may pick up the documents or pay to have the documents mailed to them. All payments must be processed before the documents are presented.

ECA counselors do not give legal advice so we strongly urge all clients to discuss with their lawyers the perceived need for a counselor's documentation, court testimony etc. and the subsequent financial burden it may cause to the client.

By signing below, you are stating that you have read and understood this policy statement and have had any questions about the policies and this document answered to your satisfaction.

Client Printed Name _____ Date _____

Client Signature _____

FEE ACCOUNTABILITY AND FINANCIAL CONSENT STATEMENT

I am aware that I must cancel an appointment within 24 hours of that scheduled appointment to avoid full financial responsibility for that session. It is my responsibility to call or text my counselor (day/night/weekend) to cancel my appointment.

I agree to the one-time charge or debit to my credit/debit card in the amount of my regular appointment fee following any missed session or appointment cancelled with less than 24 hours' notice. Elledge Counseling Associates is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **ECA**. If paying by cash, I will bring the exact amount. Counselors are unable to make change and the excess will be applied to my next session. I understand that if I choose to pay ahead for sessions, no refunds will be made for unused sessions.

If my check is returned for insufficient funds I agree to a one-time credit/debit charge to my card/account plus the NSF fee and a service charge. Elledge Counseling Associates is not required to notify me of this charge.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

If I do not return books/CD/DVD material(s) to my ECA counselor, I agree to the one-time charge or debit to my credit card/account in the amount of the replacement cost of the material(s) and credit card service fee. Elledge Counseling Associates is not required to notify me of this charge.

Credit /Debit Card Information:

Name as it appears on the card _____

Credit/Debit Card # _____

Expiration Date _____

Security Code _____

Cardholder's Zip Code _____

List all client's names this card may be used for session payment:

Cardholder Printed Name

Date

Cardholder Signature

ADULT INTAKE FORM

Date _____

Client Name _____ Date of Birth ___/___/___ Sex: M / F

Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed

Spouse's Name _____ (if applicable)

Client Address _____

City/State/Zip _____

Cell number: _____ May we leave a voicemail or text your cell? _____ Yes _____ No

Email: _____ May we contact you by email? _____ Yes _____ No

I understand that communication by voicemail, text or email cannot be guaranteed private and confidential. I agree to the risks when communicating in these ways with my counselor.

_____ Yes _____ No

Rate your current physical health: _____ Very Good _____ Good _____ Average _____ Declining

Are you under the care of a medical doctor? _____ Yes _____ No

If yes, please list name and number of doctor: _____

Are you taking any prescription medication? _____ Yes _____ No

If yes, please list the name, amount, and frequency: _____

Is your prescription medication usage a concern of yours or of someone close to you? _____ Yes _____ No

Do you drink alcohol? _____ Yes _____ No

If yes, please list type, amount and frequency: _____

Is your alcohol consumption a concern of yours or of someone close to you? _____ Yes _____ No

Do you use any type of illegal drugs? _____ Yes _____ No

If yes, please list type, amount and frequency: _____

Is your drug use a concern of yours or of someone close to you? ____ Yes ____ No

Have you ever seen a counselor before? ____ Yes ____ No

If yes, please name whom, when, and the outcome:

Have you ever received inpatient treatment before? ____ Yes ____ No

If yes, please name where, when and the diagnosis/outcome:

What is your reason for seeking counseling at this time?

Please list any religious/spiritual or cultural information about you or your family that is important for me to know. Please feel free to help me understand how your religious/spiritual or cultural beliefs are influencing you/us as we continue to work together.

Name of person(s) to contact in the event of an emergency:

1. _____
(relationship) _____
(phone #) _____

2. _____
(relationship) _____
(phone #) _____

LIMITS OF THE COUNSELING RELATIONSHIP

It's important to remember that although the sessions with your counselor may feel very intimate emotionally or psychologically, the counseling relationship is a professional one and not a social one.

The counseling relationship is governed by certain laws and ethics that are set in place for your protection as a client.

For example:

1. Contact must be limited to sessions you schedule with your counselor.
2. Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).
3. Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.
4. When the counseling relationship ends, the limitations of contact with your counselor must remain the same.

I have read and understand the limits of the counseling relationship.

Client Printed Name

Date

Client Signature

NOTICE OF PRIVACY PRACTICES

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

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which “students, trainees, or practitioners in mental health” learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third-party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

Client Printed Name

Date

Client Signature

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- “This is **Elledge Counseling Associates** calling”)
- The right to inspect and copy the information that we maintain about you. However, we *may deny an individual access*, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
 - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to *endanger the life or physical safety of the individual or another person*;
 - the information makes *reference to another person* (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
 - The request for access is made by the individual’s personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to *cause substantial harm to the individual or another person*.
 - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates 328 Pebblebrook**, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

DIRECTIONS TO OUR LOCATIONS

Red Oak

320 E. Ovilla Rd., Red Oak, TX 75154

We are located in the offices of First Baptist Red Oak. A brick electronic sign will mark the entrance to the FBRO campus and the church offices are located to the side of the sanctuary building. You may use the office parking lot and either wait on the front steps or in your car. Your counselor will be with you as soon as possible.

Waxahachie

210 YMCA Dr., Waxahachie, TX 75165

We are located in The Avenue church offices (not the sanctuary). From Hwy 77/Ferris Avenue turn west onto YMCA drive and follow it to the dead end. The church office building will be on the right. Please ring the buzzer to the right of the front door and your counselor will be with you as soon as possible.

Ferris

304 W 5th St., Ferris, TX 75125

We office inside the First Baptist Ferris/CenterPoint church. To reach the church offices you will enter under the awning. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Ennis

1200 Country Club Rd., Ennis, TX 75119

We office inside Tabernacle Baptist Church. Upon entering the parking lots look for the covered driveway entrance. Park there and you may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Duncanville

227 W. Center St., D'ville, TX, 75116

Our offices are in a white house with a red door, surrounded with a large porch and big trees. A sign in the yard will say, "Project Duncanville." The door may be locked if your counselor is with another client. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Desoto

50 W. Pleasant Run Rd., Desoto, TX 75115

We office inside Windsor Park Baptist Church. Park in the front left parking lot and enter through the doors by the "Office" sign. If the entrance is locked, ring the doorbell on the right side of the door and someone will open the door for you.

Mansfield

2271 Matlock Rd., Mansfield, TX 76063

Our offices are located within Living Church. Your counselor will give you specific directions for entry

Mesquite

2600 Eastglen Blvd. Mesquite, Tx 75181

The counseling offices are located within New Community Church. Your counselor will give you specific directions for entry

Arlington

5950 S Collins St, Arlington, TX 76018

We office inside The Grace Place Church offices. Your counselor will give you specific directions for entry.