



CONSENT FOR COUNSELING SERVICES

THE THERAPY PROCESS Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees and identify emergency contacts. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

TELEHEALTH SERVICES To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option.

There are some risks and benefits to using telehealth:

Risks:

- **Privacy and Confidentiality.** You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.
- **Technology.** At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.
- **Crisis Management.** It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

Benefits:

- **Flexibility.** You can attend therapy wherever is convenient for you.
- **Ease of Access.** You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

Recommendations:

- Make sure that other people cannot hear your conversation or see your screen during sessions.
- Do not use video or audio to record your session unless you ask your Provider for their permission in advance.
- Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.



CONFIDENTIALITY Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions:

- Your Provider may speak to other healthcare providers involved in your care.
- Your Provider may speak to emergency personnel.
- If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed. There are a few times that your Provider may not keep your personal information confidential.
- If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.
 - If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.
 - If your Provider believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you safe.

RECORD KEEPING Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

FEES FOR SERVICES AND 24-HOUR CANCELLATION POLICY You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

- **No-Show and Late Cancellation Fees will be charged for clients who do not cancel 24 hours in advance.**
 - If you are unable to attend therapy, you must contact your Provider 24-hours before your session. Otherwise, you may be subject to fees outlined in your fee agreement. Insurance does not cover these fees.
- Balance Accrual



- Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Your Provider may offer payment plans or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.
- Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.

Covered and Non-Covered Services

- When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

Payment Methods

- The practice requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

COURT RELATED FEES AND SERVICES

- Court testimony costs begin at \$250.00 an hour with a minimum charge of three hours. A retainer of \$750.00 is due one week prior to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
- It is required that a minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
- Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at \$250.00 per hour, rounded to the nearest 15-minute increment.
- In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

CY-HOPE COUNSELING CLINIC POLICIES

It is The Center's policy that any child age 12 and younger have a parent or adult guardian remain onsite for the entire counseling session.

If a client cancels and/or does not show to 3 consecutive appointments, The Center reserves the right to change the client's counselor and/or appointment time.



COMPLAINTS If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

ACKNOWLEDGEMENT: My signature on this document represents that I have received the Consent for Services form above and that I understand and agree to the information therein.

Client/Parent/Guardian Signature

Date

Client/Parent/Guardian Signature

Date



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.

Cy-Hope Counseling (the “Practice”) is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information (“PHI”), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this “Notice”), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain. Please note that your PHI is kept within a HIPPA compliant telehealth platform.

YOUR RIGHTS Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

To inspect and copy PHI: You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee. The Practice may deny your request if it believes the disclosure will endanger your life or another person's life. You may have a right to have this decision reviewed.

To amend PHI: You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request. The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To request confidential communications: You can ask the Practice to contact you in a specific way. The Practice will say “yes” to all reasonable requests.

To limit what is used or shared: You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer. You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared: You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice: You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.

To file a complaint if you feel your rights are violated: You can file a complaint by contacting the Practice using the following information: Cy-Hope Counseling 12715 Telge Rd, Cypress, Texas 77429 [Courtney Suddath or Kristin Henshaw] 713-466-1360. You can file a complaint with the U.S. Department of Health and Human Services Office for



Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The Practice will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications: The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

OUR USES AND DISCLOSURES 1. Routine Uses and Disclosures of PHI The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your health information in the following ways: To run the health care operations. The Practice can use and share PHI to run the business, improve your care, and contact you. Example: The Practice uses PHI to send you appointment reminders if you choose.

2. Uses and Disclosures of PHI That May Be Made **Without** Your Authorization or Opportunity to Object The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

- Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.
- Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.
- Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- Serious threat to health or safety: To prevent a serious and imminent threat.
- Abuse or Neglect: To report abuse, neglect, or domestic violence. To comply with law, law enforcement, or other government requests
- Required by law: If required by federal, state or local law.
- Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.
- Law enforcement: For law locate and identify you or disclose information about a victim of a crime.
- Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.
- National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.
- Workers' Compensation: To comply with workers' compensation laws or support claims.

3. Uses and Disclosures of PHI That May Be Made **With** Your Authorization or Opportunity to Object Unless you object, the Practice may disclose PHI:

- To a person or relative of your choosing if PHI directly relates to that person's involvement in your care. If it is in your best interest because you are unable to state your preference.



CY-HOPE COUNSELING
Professional Counseling Services

12715 Telge Rd.
Cypress, TX 77429
713.466.1360

www.cy-hopecounseling.org

You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing.

OUR RESPONSIBILITIES The Practice is required by law to maintain the privacy and security of PHI. The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law. The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on at the office [located at the front desk]. The Practice will inform you if PHI is compromised in a breach.

This Notice is effective on [08/30/2023].

Please sign and date this form showing that you agreed to the aforementioned terms.

Client/Parent/Guardian Printed Name

Date

Client/Parent/Guardian Signature



Patient Information Record

Patient Name (first, middle, last): _____

Date of Birth: ____/____/____ Sex: Male Female Age: _____

Race: _____ Ethnicity: _____ Language Preferred: _____

Grade, if applicable: _____ School, if applicable: _____

Street Address: _____ City: _____ St: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Texting OK? Yes No

Email: _____

(if patient is a minor, please fill in parent information for below)

Parent Name: _____

Parent Name: _____

Address: _____

Address: _____

City State Zip

City State Zip

Email: _____

Email: _____

Primary Phone: _____

Primary Phone: _____

Cell Phone: _____

Cell Phone: _____

Texting OK? Yes No

Texting OK? Yes No



COUNSELOR BACKGROUND & CREDENTIALS

I am pleased you have selected me, Danielle Mikeska, M.Ed., LPC, as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship. I earned a Bachelor of Arts Degree in Psychology from Texas State University and a Master of Education Degree in Counseling from the University of Houston. I enjoy working with children, adolescents, teens, adults, and couples. I hold a license from the state of Texas as a Licensed Professional Counselor.

COUNSELING FEE SCHEDULE

Initial Assessment	Initial interview, collection and assessment of data. Request for records from previous providers.	\$125
Individual Counseling	45 - 50 minutes per session	\$125
30 Minute Counseling Session	30 minutes per session	\$75
Group Counseling	45-50 minutes per session	\$50
Family/Couples Counseling	45 - 50 minutes per session	\$150
Consultation	Per hour to schools, parents, agencies etc...	\$125
Telephone Consultation	Over 10 minutes - No more than 50 minutes	\$125
Telehealth Counseling/Consultation	45 - 50 minutes per session	\$125
Preparation of Documents	Work/School/ or other individual or organization as requested. (Minimum of 1 week notice must be given; Does not include school/work excuse forms	\$125/hour

BILLING POLICY

1. Appointments must be cancelled **24 hours in advance** or client **will be charged** the full session fee. Payment for sessions cancelled without notice is expected prior to scheduling the next appointment.

I, the undersigned, have read and do agree to the above fee and billing policies of this office.

Client/Parent/Guardian Signature

Date



Parental Consent Form
(For persons under 18 years)

My child has my/our permission to participate in the counseling services provided by Danielle Mikeska, M.Ed., LPC. I/we understand that all materials (interview information, test scores, audio/video tapes, and other personal data) will remain confidential and will not be released to any other agency or person without my/our written consent. My/our written consent to allow my child to participate in these counseling services does not waive any of my/our legal rights.

Parent/Guardian

Address

Parent/Guardian

City/State/Zip Code

Date

(Area Code) Phone Number



Credit Card Authorization

It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modifications. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time you will be charged a full session fee. If a check is returned unpaid, you will be charged the full session fee. An additional \$25 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Please list **ALL** clients and their date of birth to be authorized to charge session fees on the card listed below:

Client name/s and date of birth: _____

I, _____, hereby authorize Cy-Hope Counseling to bill my credit card at the usual fee for professional services including all the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email or Skype consultations
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks
- Fees not covered by insurance or insurance payments make to patient rather than provider

Cardholder Information:

Name on card : _____

Address only needed if CC billing address is different than address listed above.

Address: _____ City: _____ St:

Zip: _____

By signing this form, I am authorizing Cy-Hope Counseling to bill my credit card or debit card at the usual fee for professional services. I will not dispute charges (“Charge Backs”) for sessions I have received or appointments I have missed according to the above policy.

Cardholder signature

Date

Card Type (circle one): **Visa MasterCard Discover**

Card # _____ Expiration Date: _____

Verification/Security Code (3 digit code on back of card by signature line): _____