



COUNSELING POLICIES

PATIENT FULL NAME _____ DATE OF BIRTH ___/___/___ MARITAL STATUS __SINGLE __MARRIED __OTHER
GENDER __MALE __FEMALE EMPLOYMENT: __EMPLOYED __FULL TIME STUDENT __PART TIME STUDENT __OTHER
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ LEAVE MSG? __NO __YES CELL PHONE: _____ LEAVE MSG? __NO __YES
EMERGENCY CONTACT NAME: _____ EMERGENCY CONTACT PHONE: _____

BILLING INFORMATION

BILLING FULL NAME: _____ RELATION TO CLIENT: __SELF __LEGAL GUARDIAN __OTHER
BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
BILLING PHONE: _____ LEAVE MSG? __NO __YES EMAIL STATEMENTS?: __NO __YES _____

I clearly understand that I am ultimately responsible for payment to Crystal Counseling, PLLC for any and all services rendered due at the time of the visit or upon receiving explanation of benefit information from my insurance company, whichever comes first. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations as called for in this agreement, Crystal Counseling, PLLC will have the right to forward my information to collections, and in the event it becomes necessary to utilize a collection agency to resolve a past due account, up to an additional 30% will be assessed to my account to cover the costs of this action. Crystal Counseling, PLLC will not be obligated to provide continuing services to any client who includes Crystal Counseling, PLLC as a creditor in any bankruptcy filing. My signature below indicates that I fully understand and agree to these terms.

Required for services

⇒ BILLING SIGNATURE (LEGAL GUARDIAN) _____ Date: _____

INFORMED CONSENT: My signature below indicates that I am consenting to treatment at Crystal Counseling, PLLC and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPPA). If I have questions, the information has been explained and/or summarized for me.

Required for services

⇒ SIGNATURE (LEGAL GUARDIAN) _____ Date: _____

THIS SECTION ON NECESSARY IF UTILIZING INSURANCE FOR SERVICES, PRIVATE PAY CLIENTS MAY SKIP THIS SECTION

I authorize Crystal Counseling, PLLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Crystal Counseling, PLLC. I understand that I am responsible for payment of services rendered by Crystal Counseling, PLLC, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Crystal Counseling, PLLC immediately whenever I have changes in my health condition or health plan coverage in the future.

Required to bill insurance

⇒ SIGNATURE (LEGAL GUARDIAN) _____ Date: _____

I hereby give consent below to charge my credit card for any outstanding balance for sessions. This consent will remain effective throughout the duration of sessions or one year from the date signed, whichever is sooner.

CARD NUMBER: _____ EXP DATE: ___/___/___ CVV CODE: _____ ZIP: _____

NAME ON CREDIT CARD: _____ SIGNATURE: _____ DATE: _____

PRIVATE PAY RATES	PRIMARY INSURANCE POLICY	SECONDARY INSURANCE POLICY
\$90.00 INTAKE	INSURANCE COMPANY _____	INSURANCE COMPANY _____
\$90.00 FOLLOW-UP	POLICY NUMBER _____	POLICY NUMBER _____
	INSURANCE PHONE NO. _____	INSURANCE PHONE NO. _____

COUNSELING POLICIES

Crystal Counseling, PLLC is a private practice counseling office.

We are dedicated to providing quality mental health and emotional care for our community.

What is therapy and how does it work?

Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital or couple relationship, and/or family relationships.

The therapeutic process is unique for each person. The uniqueness is comprised of your life experiences, your current experienced difficulties, your strengths, and your life goals. The therapeutic plan is developed focusing on you as a unique individual.

The process of change begins by clearly identifying the experienced problem, developing your personal goal for therapy, then discussing thoughts, feelings, and emotions in order to better understand the problem and begin developing new strategies to be able to have a healthier view of yourself, others, and life.

As a client, you have the right to ask your therapist questions about his or her qualifications, background, and therapeutic orientation. The most important factor for therapy to be beneficial is open communication between you and your therapist.

In some instances talking about your difficulties, experiences, and emotions may exacerbate your symptoms. However, over time you should see improvement and the exacerbated symptoms are replaced by a decrease in symptoms.

If at any time during your therapeutic process you have questions about whether the treatment is effective, questions about the process, or need clarification about statements or skill training, please do not hesitate to ask your therapist.

INTAKE APPOINTMENT

Please bring the following items to your intake appointment:

- ✓ Completed Personal History form
- ✓ Completed and Signed Counseling Policies form
- ✓ Photo ID (of legal guardian if client is a minor)
- ✓ Form of payment (cash, check, or credit / debit card)

If you are unable to complete the listed documents prior to coming to the intake session, please arrive at least 20 minutes early in order to complete the documents prior to the start of the session.

CONFIDENTIALITY POLICY

The staff and therapists at Crystal Counseling, PLLC have an obligation to respect your right to confidentiality regarding the information you share within this therapeutic setting. Confidentiality of client information is governed by law (Health Information Portability and Accountability Act, HIPAA) and by state law.

The state of Texas laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality.

- ✓ We are obligated to report maltreatment of minors or vulnerable adults, including physical abuse, sexual abuse, or neglect.
- ✓ We are obligated to report any prenatal exposure to controlled substances.
- ✓ We are obligated to report any serious harm you intend to inflict on yourself or another person.
- ✓ We are obligated to share information if directed by Court Order to conform to state or federal law, rules, and regulations.
- ✓ We are obligated to share information with licensing boards, which is pertinent to a disciplinary proceeding of a provider.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, if the therapist believes sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. Crystal Counseling, PLLC and group therapists are not responsible for any breaches of confidentiality by group members.



AFTER-HOURS EMERGENCIES

For after-hours emergencies, or if you need immediate assistance, **call 911**, or visit your local emergency room, medical group, or primary care physician.

Therapists at Crystal Counseling, PLLC are not available after posted business hours. You may leave a message for your therapist after-hours by calling **210-802-4695**. Your therapist will return your call as soon as possible the following business day.

LOCAL CRISIS NUMBERS

Center for Health Care Services – 210-225-5481
Child and Adolescent Crisis Center – 210-299-8139
National Suicide Prevention Lifeline – 1-800-273-8255

TELEPHONE CONSULTATION

Time spent with you on the telephone by your mental health professional, other than for appointment information, may be charged at a prorated hourly rate.

APPOINTMENTS

We realize that on occasion you will not be able to make a scheduled appointment. You can call our office and leave a voicemail if your therapist is not available at least 24 hours in advance.

Your appointment time has been reserved for you. For cancelations with less than 24 hour advance notice, our policy is to charge 50% of the private pay session rate. For missed appointments, without a cancelation notice, our policy is to charge the full private pay session rate.

Successful therapy requires a commitment from both the client and the therapist. It is important to keep your appointments.

PAYMENT POLICY

Payment is collected at the time of each session. Payment can be made in the form of cash, check, or credit/debit card.

If you need to mail payment, remit to: Crystal Counseling, PLLC
116 Gallery Circle, Suite 201
San Antonio TX 78258

There will be a **\$40 fee** for returned checks. After the first returned check, payment will only be accepted in the form of cash, credit/debit card, or money order.

CONFIDENTIALITY AND RELEASE OF RECORDS

All information regarding clients is considered strictly confidential and will not be given out to anyone without your written consent. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form.

COURT AND LEGAL PROCEEDINGS

Crystal Counseling, PLLC therapists do not perform court evaluations. Therapists do not appear in court on behalf of individuals, children or adults. Crystal Counseling, PLLC therapists are not trained for services intended for the purpose of court involvement.

Should we be called to court by a judge court order, or our records subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a \$15.00 processing fee, plus \$1.20 per page for copying.

In the event that it is necessary, by court order or subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, or present records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including, but not limited to: travel, necessary expenditures, time spent speaking with attorneys, reviewing records, and preparation of reports) at a rate of \$250.00 per hour, rounded to the nearest half hour.

The client further agrees to pay a retainer fee of \$2000.00 **two weeks prior** to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to: divorce, custody disputes, injuries, and lawsuits), neither you, the client, nor your attorney, nor anyone else acting on your behalf will call on your therapist at Crystal Counseling, PLLC to testify in court or any other proceedings, nor will a disclosure of psychotherapy records be requested. My informed consent signature shows that his litigation limitation is clearly understood and agreed to.



CLIENT BILL OF RIGHTS

Crystal Counseling, PLLC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability, or public assistance status.

Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available at Crystal Counseling, PLLC and of any financial charges that are the client's responsibility to pay.
- can expect complete and current information regarding his or her diagnosis and individual treatment plan in terms he or she can understand.
- shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- shall have the freedom to place grievances and recommend changes in policies and services to Crystal Counseling, PLLC therapists and staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, individuals receiving services from practitioners in the state of Texas have the right to: (a) expect the practitioner has met the minimal qualifications of training and has the experience required by the state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

Every client:

- has the right to be informed of and to refuse to participate in any experimental research.
- may expect courteous treatment and to be free from verbal, physical, or sexual abuse by Crystal Counseling, PLLC staff.
- has the right to a coordinated transfer of care when there will be a change of providers.
- may assert the clients' right(s) without retaliation
- has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limitations of the client's health insurance (if any).

COMMENTS, QUESTIONS, CONCERNS

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact our Clinical Director, Larry Mack at 210-802-4695 or email L.Mack@CrystalCounseling.com.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. The Health Insurance Portability and Accountability Act (HIPAA) requires us to inform you of our policy. This law requires we maintain your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into the computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send you a newsletter, or other information. We may call you to remind you of appointments. If we reach your voicemail, we may leave a message. In an emergency, we may disclose your health information to a family member or other person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the responsibility of the new owner. Except as describe above, the practice will not use, or disclose, your personal information without your written consent and authorization.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Human Services, 200 Independence Avenue, S.W. Room 509F, Washington D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Clinical Director, Larry Mack at L.Mack@CrystalCounseling.com or 210-802-4695.

MINOR CONSENT FOR TREATMENT

Please check below to indicate the current situation regarding the custody of the minor child:

- Parents are married to each other and are the legal parents of the child (one signature required)
- I am a single parent and have full legal custody of the child (one signature required)
- I am a divorced parent as sole managing conservator of the child (one signature required and a copy of the custody agreement showing parent as managing conservator required at intake)
- I am a divorced parent as possessory conservator of the child (**BOTH** signatures required)
- I am a divorced parent as joint managing conservator of the child (**BOTH** signatures required)
- I am a non-parent legal guardian and have full legal custody of the child (one signature required and legal guardianship court documents)

√ I understand that at least one parent must accompany the minor child to at least his/her first appointment.
√ I understand that Crystal Counseling, PLLC does not give recommendations or do evaluations for child custody or parenting.
√ I grant my permission for my minor child to be treated at Crystal Counseling, PLLC. and remain in force until revoked by me.

⇒ _____
Legal Guardian Printed Name

Legal Guardian Signature

Date

⇒ _____
Legal Guardian Printed Name

Legal Guardian Signature

Date

MINOR AGREEMENT

The issue of confidentiality is critical in treating adolescents. When adolescents have adults with them during sessions, what is discussed is known to all present and should be kept confidential unless disclosure is mutually agreed. Adolescents having individual sessions are not legally entitled to confidentiality (except under certain conditions). The parents of the adolescent retain the right of confidentiality of the minor. Unless an adolescent feels they have some privacy in speaking with the therapist, the benefits of therapy are lost. It is necessary to develop an arrangement for sharing information that respects the needed privacy of the adolescent, while enabling the parents access to critical information. The agreement must have the understanding and approval of the parents, or responsible adult, and of the adolescent in therapy.

This agreement regarding treatment of the minors has provisions for inserting individual details, which can be supplied by both the adolescent and the adults involved. It is first important to identify the exceptions to this general agreement. The following circumstances override the general policy that adolescents are entitled to privacy while parents or guardians have the legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve the parents as much as possible.
- Minors may independently enter into therapy and claim confidentiality in cases involving abuse, severe neglect, molestation, pregnancy, or communicable disease, and when they are on active military duty, married, officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, seeking treatment for pregnancy **other than abortion**, or if the minor is the parent of a child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party, such as a court or school are not entirely confidential and will be shared with that agency with your specific written permission. Please also note that the therapist does not have control over information once it is released to a third party upon your request.


AGREEMENT

I understand that the normal procedure for therapy with my child will be individual sessions. If I believe significant health or safety issues arise that I need to know about, I will make contact with the therapists to arrange a session when both my child and I will be present.

Similarly, when the therapist determines that significant issues should be discussed with the parents, the therapist will attempt to schedule a session involving the parents and the adolescent.

I will do my best to ensure that therapy sessions are attended and I will not inquire about the content of sessions. If my child prefers not to volunteer information about the sessions, I will respect his/her right not to disclose details. Basically, unless my child has been abused or is in clear danger to self or others, the therapist will normally tell me only the following information:

- ✓ whether session was attended
- ✓ whether my child generally participated
- ✓ whether progress is generally being made

 _____ Legal Guardian Printed Name	_____ Legal Guardian Signature	_____ Date
 _____ Legal Guardian Printed Name	_____ Legal Guardian Signature	_____ Date
 _____ Minor Printed Name	_____ Minor Signature	_____ Date