Harbor Counseling Services

www.harborcounseling.org
10330-D Lake Rd.
Houston, TX 77070-1696
(281) 382-2127

Felice Aboud, M.S.
Licensed Professional Counselor

Client Information and Consent

The undersigned therapist is a licensed professional providing mental health services to clients directly and as an independent contractor/provider for managed care companies. You will be creating a plan with your therapist in order to accomplish your counseling goals. This plan includes the number and frequency of sessions, goals and the best options to reach those goals.

Mental Health Services

Reaching out for help can be difficult, yet the rewards can be great as you gain a better understanding of your situation and resolve the issues which caused you to seek professional assistance. The therapist will facilitate the exploration of your own feelings and thoughts, and try new approaches in order for change to occur. You may bring other family members to your therapy session if you feel it would be helpful, and sometimes your therapist may suggest it.

Risks of Therapy

Therapy is the Greek word for change yet our human nature tends to be resistant to change. Personal growth can sometimes not occur until you experience and confront issues that cause you to feel sadness, frustration, anxiety, or anger. Hopefully, this would be balanced with the discovery of joy, relief, and freedom as well. The success of your work with your counselor depends on your willingness to change, and the realization that you are responsible for lifestyle choices or changes that may result from therapy. One risk of marital therapy is the possibility the marriage will not survive. Certainly, the hope when couples make the commitment for counseling is that it will improve their marriage, however, there are times when individuals make the decision to end the relationship. Individual therapy also carries risks, for instance, there is the possibility that your resistance is too great for change to occur.

Appointments

The client and therapist decide upon an appointment time that is mutually agreeable. Appointments are made by calling (281) 382-2127. Therapy appointments are 45 minutes in length. Your therapy time is reserved for you, so please call to cancel or reschedule at least 24 hours in advance. **If 24 hours notice is not given, you will be charged the customary fee of $75.00 for the missed appointment. Insurance does not cover charges for missed sessions.**

Please Initial Here:_____

Emergencies

An emergency is an urgent issue requiring immediate action. Occasionally, an emergency requires telephone counseling. Your therapist is on call twenty-four hours a day, seven days per week and can be reached by dialing the office number. While you are encouraged to telephone in an emergency, this office bills a minimum one-hour charge for emergency telephone counseling. Insurance usually does not cover charges for emergency telephone counseling. It is recommended that you utilize free telephone counseling services as an option. If you have anonymous call blocking, you will need to de-activate it to receive a return call from your therapist.

Relationship

Your relationship with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to have a social or personal relationship with you.

Payment for Services

Payment is due at the time services are rendered. If our office is filing insurance for you, you are responsible for your co-pay portion of the undersigned therapist's charges for services at the time services are provided. It is recommended that you determine your co-payment by calling your benefits office or insurance company prior to your first session.

Our office will verify your behavioral health benefits after the initial assessment. Please be informed that verification of insurance benefits does not guarantee payment by your insurance company. Any remaining balance will be your responsibility and you will be responsible for payment of all charges.

Different co-payments are required by various group coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-payment may be different for the first visit than for subsequent visits.

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the $220 per hour cost involved in producing the records, as well as preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist. Insurance cannot be filed for these types of services.

Confidentiality

Confidentiality is defined as keeping private the information shared by you, the client, with your therapist. If our office is filing insurance for you, our billing specialist will be required to provide some information, primarily your diagnosis, to your insurance carrier. Some Employee Assistance Programs also require relevant information in order to authorize sessions at no charge to you. No information will be released to anyone not performing business for this office without your consent unless mandated by Texas law. You may request an accounting of all disclosures made of your records, and, whenever it is possible, any disclosure of your healthcare information to an outside individual or agency will be discussed with you prior to disclosure.

Please be advised that, although protecting your confidentiality is a priority for your therapist, Texas law mandates several exceptions to your right to confidentiality. Possible exceptions to confidentiality include, but are not limited to, the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; licensing board investigations; criminal prosecutions; child custody cases; lawsuits; situations where the therapist has a duty under the law to disclose, or where, in the therapist's judgment, it is necessary for safety to warn or disclose; fee disputes between the therapist and the client; or filing for insurance reimbursement.

If you have questions regarding confidentiality, you should bring them to the attention of your therapist. Please be advised that by signing this information and consent form, you are giving your consent to your therapist to share confidential information with all persons mandated by law, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Custodian of Records

If your therapist should need to close her practice for an emergency requiring a prolonged or permanent absence, it may become necessary for your file to be passed to a new custodian for safekeeping. You have the right to inspect, copy, or request that your therapist amend the information maintained in your record.

By signing this information and consent form, you are acknowledging that, in the event that the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records for safekeeping. By signing this information and consent form, you give your consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of your file and records. In this way, your records may be maintained and protected as confidential.

Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature Date

_____ _____

Felice Aboud, LPC
Harbor Counseling Services

Date

Client Personal Information

Today's Date: _____ Gender: M F

Name: _____
(First) (Last) (Middle)

Home Address: _____
(Street Address) (Apt. Number)

_____
(City) (State) (Zip Code)

Preferred Contact: (_____) _____ SSN: _____

Date of Birth: _____ Marital Status: _____

Employer: _____ Work Phone: (_____) _____

Student Status (if attending school): Full-time Part-time

Who recommended us or referred you to this office? _____

Policyholder Information

If you wish this office to file insurance or EAP benefits for you, please complete the following.

Insured's Name: (Name of Policyholder) _____

Insured's Home Address: (If different from client's) _____

Insured's Home Phone: (_____) _____ Insured's Work Phone: (_____) _____

Client's Relationship to Insured: (e.g. spouse, son): _____

Insured's Employer: _____

Insured's Birthdate: _____ Insured's Social Security Number: _____

AUTHORIZATION NUMBER GIVEN BY YOUR INSURANCE COMPANY: _____

NUMBER OF SESSIONS WITH THE AUTHORIZATION: _____

IF YOU ARE USING YOUR EAP BENEFITS:

NAME OF EAP: _____

AUTHORIZATION CODE: _____ **NUMBER OF SESSIONS:** _____

Please Initial Here: _____

Please identify the issues you would like to discuss (in order of importance):

1. _____

2. _____

3. _____

4. _____

Have you lost something of importance in the past two years? (e.g. spouse, pet, job, friend, health)

_____

_____

_____

What are the names and ages of the other individuals living in your home with you?

_____

_____

Do you have children not currently living with you?_____

Please list any medications you are currently taking:

	Name of medication	Purpose of medication	Dosage
1.			
2.			
3.			

Name of the Physician who is monitoring your medication: _____

By signing below, you are authorizing this office to file insurance and EAP claims for you and receive payment directly from your insurance carrier.

I, the undersigned, on this date have requested that my therapist accept assignment of my insurance benefits for charges for mental health services rendered to me. I authorize payment of medical benefits directly to the supplier of services. I agree to sign any and all forms necessary for the submission of a claim for payment of benefits to my therapist by my insurance company. I hereby consent and authorize the undersigned therapist and her staff to provide my insurance company with any and all information requested by my insurance company in connection with its review and consideration of the claim for payment of benefits. I acknowledge that I am waiving my right to confidentiality with respect to the records and information requested by my insurance company or employee assistance program, as well as the managed care company and/or insurance carrier responsible for providing my mental health care services and payment for those services. I understand that I may revoke this authorization at any time, in writing, and that such revocation will apply to my records except to the extent that action has been taken prior to such revocation in reliance on this authorization. I hereby release and hold harmless the undersigned therapist and her agents and staff from any and all liability arising from release of the information and records requested.

SIGNED this_____day of_____, 20 _____ .

_____

Client Signature

_____

Felice Aboud, LPC
Harbor Counseling Services

Message Authorization

Authorization to Leave Messages with Household Members, Voice Mail, Email and/or Text Messaging.

From time to time it is necessary for representatives of Harbor Counseling Services to contact clients for various reasons and/or to leave a message. The usual purpose of a message is to remind clients that they have an appointment or to ask a client to call our office regarding an issue or concern. At no time will a representative of Harbor Counseling Services discuss your case, circumstances or condition without your consent. The purpose of this form is to designate the method that is acceptable for contact and/or grant consent to leave messages with members of your household or on your voice mail.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please note: Electronic communication (Email or Texting), although intended only for the use of the individual or entity to which it is addressed, is not guaranteed to be secure.

Please fill in requested information and initial beside each method through which you grant permission to be contacted:

Email: _____ initial _____

Text: _____ initial _____

Voice Mail

Home: _____ Initial_____

Cell: _____ Initial_____

Work: _____ Initial_____

Should someone other than yourself answer the phone above, may we leave a message with this person? Yes No Initial _____

Client Name: _____

Client Signature: _____ Date: _____

Please Initial Here: ____

HIPPA ~ NOTICE of PRIVACY ~

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order for HCS to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.
6. In accordance to Texas Chapter 611, Mental Health Records Release protocol.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a notarized, written release. However, under certain rare circumstances your request can be denied. In some circumstances, a summary of treatment report of services rendered will be provided. Requests for records will be honored within 15 days after receiving a proper request has been filed with HCS.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

As a private practitioner, I have the responsibility to:

1. Make each client aware to review HCS Privacy Notice via HCS website and/or hardcopy.
2. To make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated, you have the right to contact The U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/.

I have reviewed and understand this notice.

CLIENT:_____

CLIENT SIGNATURE:_____

DATE: _____DOB: _____

SIGN BELOW IF A CHILD 18 YEARS AND UNDER:

IF THE MINOR CLIENT IS NAMED IN A CUSTODY AGREEMENT OR COURT ORDER, YOU SHALL GIVE PTHE TREATING PROVIDER A FULL COPY OF THE CUSTODY AGREEMENT AND/OR COURT ORDER, AS WELL AS ANY DIVORCE DECREE. IT WILL BE MAINTAINED IN THE MINOR CLIENT'S FILE. IT IS THE RESPONSIBILITY OF THE PARENT TO PROVIDE ANY AND ALL UPDATED DOCUMENTS SHOULD IT OCCUR DURING THE TIME OF TREATMENT.

MINOR: CLIENT NAME: _____ Date of Birth: _____

PARENT SIGNATURE AND RELATIONSHIP TO CLIENT: _____