JAMIE LEONARD, MED, LPC-S

COUNSELING SERVICES AGREEMENT

This document contains important information about my professional services and business policies. Please read it carefully and be sure to let me know if you have any questions. If you decide to sign this document, it will constitute an agreement between us.

APPOINTMENTS AND FEES

Sessions are 45-50 minutes and the fee is $250 for individual and $300 family/couples therapy sessions. In addition to appointments, I charge this amount for other professional services you may need, such as report writing, telephone conversations, consulting with other professionals with your permission, school consultations, preparation of records or treatment summaries.

You will be expected to pay for each session at the time it is held. **Once an appointment is scheduled, that time has been reserved for you alone so you will be responsible for payment of full amount unless you provide 24 hours advance notice of cancellation.** For those paying with a credit card, if you do not cancel within 24 hours, your credit card will be charged for the missed session.

LEGAL FEES

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I charge $250.00 per hour for preparation/travel and $350.00 per hour for attendance at any legal proceeding.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most

situations, I can release information about your treatment to others only if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations involving uses and disclosures for treatment, payment and healthcare operations that require only that you provide written, advanced consent. The Notice of Privacy Practices also describes these uses and disclosures for treatment, payment and healthcare operations. You have the right to and should review the Notice of Privacy Practices before signing this Agreement. **Your signature on this Agreement provides consent for uses and disclosures for treatment, payment and healthcare operations such as the following**:

- I may occasionally find it helpful to consult with other health and mental health professionals about a case. During consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to

keep the information confidential. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Privacy Practices). I may also need to consult with another health care provider, such as your family physician or another therapist to coordinate or manage your health care and other services related to your health care.

• If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

• If you are involved in a court or administrative proceeding and a request is made for information concerning my professional services, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

• If a government agency is requesting the information for health oversight activities,

• If you file a complaint or lawsuit against me,

• If you file a worker's compensation claim.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment.

• If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Child Services. Once the report is filed, I may be required to provide additional information.

• If I have reasonable cause to believe that a disabled adult or elder person has been neglected or exploited,.

• If I determine that a client presents a serious danger of violence to another or himself, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights are described more fully in the Notice of Privacy Practices.

Pursuant to HIPAA, I keep Protected Health Information. Your Clinical Record includes information about reasons for seeking therapy, a description of the ways in which your problem impacts your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone. Except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy of your Clinical Record, if requested in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend we review them together, or have them forwarded to another mental health professional so you can discuss the contents. Normal hourly charges and/or copying charges will apply.

MINORS AND PARENTS

Minors have a limited right to privacy in that their parents may have the right to access their records.Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, we need to consider carefully the clinical ramifications of parents viewing their child's record. It is my preference to provide parents only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

REFERRALS

There are times when I am not able to provide services for all conditions or challenges that clients face. For this reason, a referral may be required. If so, I will provide you with some alternatives. It will be your responsibility to contact and evaluate those referrals.

ELECTRONIC COMMUNICATION

Note: All information and correspondence made through your personal account which is setup on the website has protected transmittion through a portal that is encrypted.

Do not use email or text messaging for emergencies.

For after hours emergencies or if you are in need of immediate assistance, call 911 or visit your local emergency room, medical group or primary physician.

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOUR SIGNATURE PROVIDES CONSENT FOR THESE USES AND DISCLOSURES.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

II. Uses and Disclosures with Neither Consent nor Authorization

• **To Avert a Serious Threat to Health or Safety** – If it is determined that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

• **Abuse of Child, Disabled Adult or Elder Person** – If I have reasonable cause to believe that a child, disabled adult or elder person has been abused, I must report that belief to the appropriate authority.

• **Health Oversight** – If I am the subject of an inquiry by the Texas Board of Licensed Professional Counselors, I may be required to disclose PHI regarding you in proceedings. Additionally, I may be required to disclose PHI if audited by Secretary of Health and Human Services to assess compliance with HIPAA regulations.

• **Judicial and Administrative Proceedings** – If you are involved in a judicial or administrative proceeding, I will not release information without your authorization or a court order.

• **Worker's Compensation** – I may disclose PHI regarding you as authorized to comply with laws relating to worker's compensation.

III. Uses and Disclosures Requiring Authorization

Uses or disclosures of PHI for other purposes above and beyond the general consent will be made only with your written authorization.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

• **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of PHI.

• **Right to Receive Confidential Communications by Alternative Means or at Alternative Location** – You have the right to request to receive confidential communications of PHI by alternative means or at an alternative location. Submit requests in writing and specify how or where you wish to be contacted.

• **Right to Inspect and Copy Protected Health Information** – You have the right to inspect and obtain a copy of PHI and billing records for as long as the PHI is maintained in the record. I may provide a summary or an explanation of the PHI to which access has been provided in lieu of copy of records if deemed necessary.

• **Right to Amend Protected Health Information**– If you feel that PHI about you is incorrect or incomplete, you have the right to request an amendment of PHI. Submit your request in writing and provide a statement that supports your request. I may not be able to make the changes you request, however your request and statement will be included in your file.
• **Right to an Accounting** – You have the right to receive an accounting of disclosures of your PHI that I have made in the six years prior to the date on which the accounting is requested.
• **Right to a Paper Copy of This Notice** – You have the right to obtain a paper copy of this Notice upon request.

Therapist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I am required to abide by the terms of the privacy notice that is currently in effect.
• Please note that I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI I maintain. A copy is posted on my Web site (www.houstoncounselor.net).

I utilize electronic systems to store some of your PHI. Should a breach in security occur, we are required to notify you within 60 days of the occurrence of the breach.

V. Complaints

You may file a complaint to the Department of Health and Human Services, 200 Independence Avenues, S.W., Washington, D.C 20201, calling 1-877-696-6775. You may assert your right without retaliation. Before filing a complaint, or for more information regarding your health information privacy, please contact me at 713-410-0926.

COUNSELING SERVICES AGREEMENT & NOTICE OF PRIVACY PRACTICES SIGNATURE

I have read, understand, and agree to abide by the terms and conditions set forth in the Counseling Services Agreement (CSA), and do hereby consent to participate in the treatment as described by in the CSA. Additionally by signing the CSA , I signify that I understand and agree to the terms of Electronic Communication. I understand that my participation is entirely voluntary, and that I may withdraw my consent and terminate at any time.
Signature is acknowledgement of receipt of Notice of Privacy Practices (HIPAA).

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Legal Guardian Date