**IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign electronically.**

**CLIENT INFORMATION AND INFORMED CONSENT: GENERAL**

I am excited to walk with you on this next leg of your personal journey, no matter how long or short our time together may be, as you seek positive change in your life and relationships. It is my aspiration that you heal and grow from the therapeutic experience. To make an informed decision about utilizing my services, it is important for you to know some things about me professionally. I hold a Master's in Counseling from the University of North Texas, a license from the Texas State Board of Examiners of Professional Counselors, and a certificate from the National Board for Certified Counselors. I also have specialized training in Anxiety, Couples' Counseling, Traumatic Brain Injury, Anger Management, and Life Coaching. I work primarily with adults, older adolescents, and couples on a variety of issues. The treatment approach I use is eclectic, pulling techniques from a variety of theories to best suite your needs and personality. Such techniques could include cognitive restructuring, relaxation training, re-framing, self-monitoring, experiments, awareness exercises, dialogue, formal assessment, problem-solving, mindfulness, spiritual development, coping skill education, visualization, and assigning homework. Thinking patterns are frequently addressed and psycho-education is an important part of your treatment. I work from the perspective that therapy is a collaborative effort, in which the therapist and client(s) share the responsibility for the outcome. During the initial session, you and I will determine more precisely what has brought you to counseling and will together establish treatment goals. Sessions are approximately 55 minutes.

**Effects of Counseling:** Please be aware that benefits of therapy are expected though not guaranteed and therapy comes with potential emotional risks. Personal issues addressed may bring to the surface uncomfortable emotions such as anger, anxiety, and sadness. Sometimes things get worse before they get better. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to your existing relationships. Most people who take these risks find therapy is helpful for improving relationships, reducing feelings of emotional distress, and specific problem solving. I will do what I can to help you minimize risks and maximize positive outcomes. If you note distress as a result of therapy, please bring this to my attention so that we can work through it, as this in and of itself can be a powerful aspect of the therapeutic process.

**Counseling Relationship:** The counseling relationship is unique to any other relationship in that it can be very intimate but is strictly professional. Engaging in social or sexual relationships is something I will avoid as it is potentially harmful to you and is a breach of ethics. It could be harmful by impacting my clinical judgment, objectivity, or therapeutic effectiveness or could be exploitative in nature. For this reason I cannot accept an invitation to social gatherings, accept gifts, or in any other way relate to you outside of the professional context of our counseling sessions. This includes not accepting any invitations via social networking sites such as Facebook, Twitter, or LinkedIn, nor will I respond to blogs written by clients.

**Clients Rights:** The amount of time a person needs to be in therapy to sufficiently accomplish his or her goals varies, for a number of reasons. As a client you are in control and may end our counseling relationship at any time. You are never under any obligation to continue or to comply with techniques or a direction of therapy that you do not understand or are uncomfortable with, and may request a discussion of the reasoning, modification or termination of such.

**Termination & Referral:** During the intake and initial sessions, as well as while assessing your progress along the way, I will assess if I can be of benefit to you. If, in my opinion, I cannot be of help to you or you need a different type or level of care, I will recommend termination and provide you with referrals that you may choose to contact. If you feel that my services are no longer of benefit to you, you are welcome to initiate termination and request referrals. Once referrals have been provided and options discussed, you will be responsible for contacting and evaluating those referrals. I am willing to facilitate the transition from my services to theirs via consult, with your written permission. Once it is determined collaboratively (by both you and me) that your therapeutic goals have been successfully achieved and you are no longer in need of services, a termination session will be conducted. At that point follow-up care of any kind will be discussed.

**Confidentiality:** I follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between you and I are confidential. No information will be released without your written consent unless mandated by law. 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; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suites in which the mental health of a party is an issue; situations where I have duty to disclose, or where in my judgment, it is necessary to warn or disclose; fee disputes between you and I; a negligence suit brought by you against me; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention and we will discuss this matter further. By signing the Consent for Treatment form, you are giving me consent to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding me harmless from any departure from your right of confidentiality that may result.

I will not make electronic recording of any contacts or interview without your specific written permission.

In the unlikely event that we should ever meet in public or a social situation, your confidentiality will be protected in that I will not acknowledge you unless you wish to do so and initiate communication.

There may be times when I might consult with professional colleagues to gain greater insight and feedback regarding work we are doing in order to serve you better. If I do so, I will not use your name or any information that could identify you.

Confidentiality and Couples: When a person who engages my services for couples' counseling is seen individually, a "no secrets" policy is in place. This means information shared will be approached sensitively as is necessary but will not be withheld as confidential between that one member of the couple and me.

**Records:** I maintain brief records of dates of service, issues addressed, interventions, progress, recommendations, ongoing concerns, and any homework assigned. Records are kept via secure means in a locked file or electronically under password protection. You have the right to a copy of your file at any time. You have the right to request a correction to any errors in your file. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Please be aware I may request a waiver of this right if I believe it would be more harmful than helpful for you to have copies of your records and will alternately provide you with a summary of treatment.

**Managed Mental Health Care:** If your counseling is being paid for in full or in part by a 3rd party agency (such as insurance or employee assistance programs) there is additional information you should be aware of. 3rd party payers have the right to impose restrictions on number of sessions, time period to complete therapy, use of medication, and methods of treatment. Some organizations require detailed reports of your treatment and progress in counseling and, on occasion, may require a review of your entire case file. Information collected by 3rd party payers usually becomes a part of your permanent health record at the Medical Information Bureau and they may not maintain the same high level of privacy and confidentiality regarding your records that I would. If any of this is of significant concern please ask to discuss your options.

**Incapacity or Death:** In the event of my death or incapacitation, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of your treatment records. By your signature consenting for treatment, you hereby consent for Conchita Andrijeski, LPC-S to take possession of your records and provide you copies at your requests, and/or to deliver those records to another therapist of your choosing.

**Complaints:** If you are unhappy with what is happening in therapy, please discuss it with me so that I can respond to your concerns. Concerns will be taken seriously with care and respect with no negative repercussions should you chose to continue our therapeutic relationship. If you believe I have been unwilling to listen and respond, or that I have behaved unethically, the complaint about such behavior can be directed to the Texas Behavioral Health Executive Council at https://www.bhec.texas.gov/discipline-and-complaints/index.html or 512-305-7700 or 333 Guadalupe St., Ste. 3-900, Austin, TX 78701.

**Policies and Procedures**

The following policies and procedures are in place to facilitate the best therapeutic service for all of my clients. Please feel free to ask any questions you may have about them.

Termination: Once it has been mutually determined that therapeutic goals have been met termination will be conducted during all or part of your final session. If a session has been missed and not rescheduled or there has been no contact from you for 2 months following your last session, our therapeutic relationship will be considered terminated. After termination you will no longer be considered a client but in most cases may return again if necessary.

Canceling appointments/No shows: Please cancel 24 hours or more in advance, unless there is an emergency. This can be done either by calling or canceling/rescheduling yourself on the portal. If canceling less than 24 hours for a non-emergency you will be responsible for the late cancellation/no show fee. See Informed Consent: Financial Policies for details.

Late Arrivals: You will have a 15 minute grace period following your scheduled appointment time. If you arrive past that you may be asked to reschedule.  
Appointment Reminders and Appointment Scheduling: You may choose to receive an email or text message the day before your scheduled appointments. This service is provided as a courtesy. A 3rd party is used to handle these reminders so there may be circumstances in which messages will not be successfully delivered (if users are on the phone, out of service, etc). It is YOUR responsibility to record and keep any appointments that have been made, as I cannot guarantee you will successfully receive a reminder every time.

You can enjoy the convenience of viewing your appointment time and scheduling/rescheduling online 24/7 through the Client Portal or by calling 214-417-7803 during normal business hours.

Clinical Emergencies: If you find yourself in a state that you need to speak with someone immediately, cannot wait until our next appointment, and are unable to reach me, 24/7 help can be found for anyone at www.befrienders.org. If you are in immediate danger of harming yourself or someone else, call 911 or go to the nearest medical ER or psychiatric facility such as:

Tarrant County: Fort Worth Crisis Intervention at 817-927-5544, John Peter Smith Hospital Emergency Room at 817-927-1110

Dallas Country: Dallas Suicide and Crisis Center at 214-828-1000, Parkland Psychiatric Clinic at 214-590-5536, Parkland Emergency Room at 214-590-8761

**Informed Consent: Financial Policies**

It is important that you be clearly informed of your financial responsibility when engaging in services with Mind In Balance, PLLC. Please read carefully and ask any questions you may have.

Payment is due at the time services are rendered. A new session may not be scheduled if a client has a past due balance (client portion only).

**Fees for Counseling/Psychotherapy Services**

00000 Initial Phone Consult, 10 min. $0.00

90791 Initial Intake Session (Diagnostic Evaluation), 50 min. $145.00

90832 Individual Psychotherapy, 16-37 min. $70.00

90834 Individual Psychotherapy, 38-52 min. $125.00

90837 Individual Psychotherapy, 53-60 min. $130.00

90846 Family/Conjoint Psychotherapy without patient present, 50 min. $130.00

90847 Family/Conjoint Psychotherapy with patient present, 50 min. $130.00

Couples/Marital Therapy, 53-60 min. $130.00

Couples/Marital Therapy, 85-90 min. $170.00

Payment may be made via credit card on file, or cash, or check made out to Mind In Balance, PLLC. Virtual sessions must be paid via credit card.

**Paying with Insurance or an Employee Assistance Program (EAP)**

EAP benefits may be used if you have a short term problem that may or may not involve a mental health diagnosis. Each requires basic information about your needs to be reported to them and they are required to keep the same level of confidentiality with your employer that therapists and insurance companies are. Sessions are very limited in number, usually 3-8 and are covered at no cost to you.

Insurance benefits for mental health and substance abuse vary greatly and often differ from your medical policy. They require that it be "medically necessary" for you to engage in treatment and that your diagnosis be reported to them. Your diagnosis will remain a part of your permanent medical record. Insurance companies are required to follow the same strict HIPAA guidelines that your therapist is, though it is another set of eyes on your information and they do have the right to ask to review all of your clinical records. Some choose not to use insurance so that there is additional freedom with clinical goals and length and type of service, as well as an additional layer of privacy. Others find using benefits to be helpful in decreasing the cost. If you choose to use insurance:

1. You must have a diagnosis (either previously diagnosed or diagnosed in the first few sessions) that meets criteria for medical necessity.

2. You are responsible to pay your portion. This could be 1.)the full allowed amount because your deductible has not been met, 2.) a copay - this is a flat fee usually around $20-$35 per session (but varies greatly from $10-$75), 3.)a co-insurance - this is a percentage which varies greatly per contract, or 4.) $0.00 if your insurance covers outpatient therapy at 100% or you have reached your out-of-pocket max.

3. It must be an insurance that Mind In Balance, PLLC therapists are in network with. Otherwise, you may choose to use your out-of-network benefits. This means you are responsible to pay the full session rate at the time of the session and then you will be responsible to submit the Super Bill (can be obtained through the Mind In Balance, PLLC Client Portal) to your insurance for reimbursement.

**Anthem, BCBS, and some EAPs**

If your mental health insurance is through Anthem or BCBS please call them prior to your first session so you know what you are responsible for (ask what your current cost would be per session for outpatient counseling). Following each session Mind In Balance, PLLC will charge the portion you are responsible for to your card on file (or collect your cash or check in-person) and will file the insurance claim for you.

Mind In Balance, PLLC will ask you to complete any forms required by your particular EAP during the first session and will bill all EAPs for you.

**Aetna, Cigna, Optum/United Healthcare, and some EAPs: Alma**

If your mental health insurance is Aetna, Cigna, Optum (including many Optum subsidiaries), Mind In Balance, PLLC has partnered with Alma to manage the billing and will not file claims with the insurance companies directly. You will be asked during the intake process to register your insurance information with Alma and will have the option to set up Auto Pay for the portion you are responsible for. Alma will bill your insurance on your behalf and will either charge the card you set up with auto pay or will invoice you for your portion. No regular session fees will be charged directly by Mind In Balance, PLLC unless you incur a no show/cancellation fee. In that case you will be charged nothing by Alma but will be charged the $80.00 by Mind In Balance, PLLC.

**Additional Information about Paying with Insurance**

In most cases insurance does not consider family or couple relationship problems to be "medically necessary." Some benefits cover family sessions but those are to help with the goals of individual clients and are not the same thing as couples counseling, in which the relationship is the client. Therefore, Mind In Balance, PLLC therapists will not bill insurance for true couples counseling. EAPs will cover couples sessions and are a great option for short term couple issues. If you are seeking couples counseling please discuss payment options in more detail with your therapist.

In the event that your insurance company is billed and they deny your claim that was filed correctly, you assume financial responsibility for those sessions. If your insurance changes in the middle of the year please notify your therapist as soon as possible so that you do not incur unexpected expenses due to lapse in insurance.

If you have mental health/substance abuse coverage with an insurance company that Mind In Balance, PLLC therapists are contracted with but you prefer not to have your insurance company billed, Mind In Balance, PLLC will not bill your insurance directly nor through Alma but will charge you their allowed amount for services, not the standard cash pay rate.

**Fees for Non-Therapeutic Services**

Occasionally needs arise in which therapists are requested to do things other than regularly scheduled therapy. The following fees apply, are due at the time of delivery, and are not payable by insurance. Talk to your therapist if a payment plan is required.

Any in-person visit outside the office (inpatient visits, court, collaborative law services, etc.), including drive time $250.00/hr

Written Reports/Paperwork\* (insurance companies, supervisors, court/legal, etc.) $125.00/hr

Insufficient Funds/Returned Check Fee per item $25.00

\*Mind In Balance, PLLC therapists will not complete paperwork for FMLA, Short-Term Disability, Long-Term Disability, or Workman's Compensation claims. These are most appropriate to request from your medical doctor. A therapist may, at his/her discretion, complete supplemental mental health paperwork for any of the above for the fee listed.

**No Show/Late Cancellation Fee**

The time you are scheduled has been reserved especially for you so please make every effort to keep your appointment. If something comes up, as happens in life, please communicate any need to cancel or reschedule by calling 214-417-7803 or logging into the portal and canceling/rescheduling yourself prior to 24 hours. If a session is cancelled within that time period or a client does not show up for a session, the therapist will automatically charge the no show/late cancellation fee of $80.00 (or the full cost of the session if less than $80.00) to the card on file. If there is a hardship or true emergency (illness you were unaware of the previous day, car accident on the way, etc.) please let us know and the fee will be refunded in full. A change in work schedule last minute is not your fault but is not considered an emergency. If you are able to reschedule the session that same week or if there are any other unusual circumstances the therapist may waive the fee at his/her discretion. If you are scheduled for an in-person session you may request to transition to a virtual session even up to the start of the scheduled session and there will be no late cancellation fee.

**Informed Consent: Virtual Therapy/Counseling (telephonic or video chat)**

Engaging in therapy/counseling services via the internet has a multitude of benefits. It also comes with some additional risks. Please be sure to read carefully and ask any questions that arise.

Please be aware that extensive steps are being taken by me to ensure your confidentiality. It is also important on your end that whenever we conduct a session, you find a secure, private space where you cannot be overheard and are using a secure internet connection. By signing the consent form you are acknowledging that you will not hold me, Jolene McVean, LPC, responsible for any situation in which your confidentiality may be breached due to action/inaction on your part.

Please note, technical difficulties are a realistic possibility at any time for a variety of reasons and are often outside of your control or mine. If there are glitches in session, attempts will be made to get back on track and to provide you with the full time allotted not including the disruption time. In the event the session is unable to be completed, all or part of the session may need to be rescheduled at no additional cost to you. If there are problems with a video chat, it may be an option to switch to telephonic to complete that session.

Please keep in mind that body language can sometimes be perceived slightly differently and verbal communication can be challenging via video connection as opposed to face-to-face interactions. Eye contact is very different because one must actually look directly into the camera to appear to be looking at the other person's eyes. Additional clarifying questions may be necessary to make sure you are completely understood so that nothing is missed by using this medium of communication. Please feel free to inquire of me if you are unsure about what I may be verbally or non-verbally communicating.

Current laws and ethics stipulate that I only practice within the state in which I am licensed. That means I can and will only see clients who reside in the state of Texas. I require proof of residency prior to providing any online services by obtaining a copy of some form of legal ID with a photograph and address, such as a driver's license.

**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 THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

**HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

**For Payment.** I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.**Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization include:

Using or sharing your information for health research, when approved by an institutional review board.

For workers' compensation claims

For law enforcement purposes or with a law enforcement official

Required by law, such as the mandatory reporting of child/elder abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department) or health oversight organizations

Required by Court Order or in response to a subpoena or other judicial and administrative proceedings

Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public (Duty to Warn). If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

For special government functions such as military, national security, and presidential protective services

Complying with the law: I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I'm complying with federal privacy law.

I can share health information about you with organ procurement organizations.

I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already may use of or disclosed information based upon your prior authorization. I will only make the following uses or disclosures with your written permission: (1) most uses and disclosures of psychotherapy notes, except when legally requested; (2) most uses and disclosures of PHI for marketing purposes; (3) disclosures that constitute a sale of PHI; and (4) other uses and disclosures not described in this notice. Further details are included in my Informed Consent Form.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Jolene McVean, LPC, at 410 NW 11th St., Suite 111, Grand Prairie, TX 75050.

**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. You may also request that a copy of your PHI be provided to another person.

**Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

**Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

**Breach Notification.** If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself

**Right to a Copy of this Notice.** You have the right to a copy of this notice.

**COMPLAINTS**

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with Jolene McVean, LPC, the Privacy Officer, at 410 NW 11th St., Suite 111, Grand Prairie, TX 75050, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

***By your electronic signature, which has the same weight of a hand drawn signature, you are acknowledging that you understand the general policies, financial policies, privacy policies and virtual session policies, and when and how they apply to you, and you are agreeing to them.***