1006 N. Bowen Rd.
Suites 200 D-I
Arlington, TX 76012
Phone: 817.460.1019

Founding Members
Dr. Lucas: 740.802.4399
Dr. Manuel: 937.329.1298
Fax: 817.394.5075

Agape Psych Services

INFORMED CONSENT FORM

Welcome to Agape Psych Services! We look forward to helping address your current life situations that have influenced you to seek mental health services. Below you will find information about our agency, policies, HIPPA, and the guidelines of confidentiality.

PSYCHOLOGICAL SERVICES

Individual Therapy

The frequency of our meetings will depend on your treatment goals. Initially, **50min** sessions will be scheduled weekly in most cases, unless otherwise agreed upon.

Couples and Family Therapy

The frequency of our meetings will depend on your treatment goals. Initially, **60-90min** sessions will be scheduled weekly in most cases, unless otherwise agreed upon.

Consultations, Trainings, and Workshops

The frequency and rates for corporate consultations, trainings, and workshops will vary. Contracting is negotiable.

CANCELLATIONS

We fully understand that schedules can change, and at times you may need to reschedule. We request that you give 24-hour notice of cancellations. You will be allowed 1 late cancellation (less than 24-hour notice) and 1 no show (failure to attend session). After these grace allowances, you will be charged a fee of $50. Any late cancellation or no-show during holiday season (i.e., week of Thanksgiving, Christmas, and New Year, etc.) will be charged the full session fee even if it is a first occurrence.

PROFESSIONAL FEES

Potential clients will be offered a free 15-minute phone consultation to review treatment issues, answer initial questions, and determine if a therapist at Agape Psych Services would be a good treatment match. If we decide to schedule a full session, the fee for service rate will be $150, due at the time of service. If a client is experiencing financial hardship, they can discuss our sliding scale fee schedule.

If you become involved in legal proceedings that require our participation, you will be expected to pay for all the professional time of use with the therapist you are working with including preparation; transportation costs; and research and preparation. Because of the difficulty of legal involvement, we charge $200 per hour for preparation and attendance at any legal proceeding with a minimum of 4-hour time.

BILLING, PAYMENTS, AND INSURANCE

You will be expected to pay for each session at the date of service, unless we agree otherwise. We accept debit or credit, cash, checks, or money order. There is a $25 returned check fee. We can accept

insurance Health Savings Accounts payments. We ask clients to leave a credit card on file to be processed in the case of late cancellations or missed appointments.

Please be aware the therapists at Agape Psych Services have limited participation with insurance panels to ensure more therapeutic freedom. If you plan to use insurance, we will review benefits prior to your first session. You will be responsible for paying any copays, co-insurance fees, or deductible rates at the time of service. If you should wish to submit for out of network claims, we will be happy to provide you documentation of service, but we cannot guarantee reimbursement. Clients are responsible for fees that are not covered by insurance providers.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

CONTACTING US

The therapists at Agape Psych Services can schedule their own appointments and get all messages via voicemail, email, or text message. Some appointments can be setup if you call our office, by our independent practice manager. We check our voicemails as our appointment schedule will allow. We will make every effort to call you back within 1 business day.

If you are experiencing a life-threatening emergency or if you are unable to wait until your call is returned, contact your family physician, psychiatrist, or the nearest emergency room and ask for the psychologist or psychiatrist on call.

If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

Email and text messages can be used for scheduling purposes, but not for out-of-session therapy. Although electronic communication can be a more convenient form of communication, we cannot guarantee security of electronic correspondence. **We may not respond to messages after 7pm.**

THE NOTICE (HIPPA)

The Health Insurance Portability and Accountability Act (HIPAA) requires that we address with you a Notice of Privacy Practices (the Notice) for use and disclosure of Personal Health Information (PHI) for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. When you sign this document, it will represent an agreement between us about our work together and that you have received HIPAA information. You may revoke this Agreement in writing at any time. That revocation will be binding, unless we have taken action in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

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LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, therapists at Agape Psych Services can only release information about your treatment to others if you sign a written Authorization form.

There are, however, other situations that require only that you provide written, advance consent. Your signature on this Informed Consent Form provides consent for the following activities:

• We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to your treatment. We will note all consultations in your Clinical Record

• Disclosures required by health insurers or to collect overdue fees will be made

• If a patient threatens to harm himself/herself or an identifiable other, we are 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 required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a court order is issued for information concerning the professional service provided. Such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization. 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 to audit health oversight, we may be required to provide it to them.
- If a patient files a complaint or lawsuit against APS, we may disclose relevant information regarding that patient in defense.
- If a patient files a worker's compensation claim, and getting services related to that claim, we may provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which we are legally obligated to take actions in efforts to protect others from harm and we may have to reveal some information about a client's treatment:

- If we become aware that a child under 18 is or has been the victim of physical abuse, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that we file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we become aware that an elderly adult or an adult with mental or physical disability is or has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually the Office of Adult Protective Services. Once such a report is filed, we may be required to provide additional information.
- If a client communicates an explicit threat to harm themselves and cannot contract for safety, we must take protective actions that may include notifying law enforcement, family members, and local emergency services in attempts to save and seek hospitalization for the client.
- If a client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and we believe that the client has the intent and ability to carry out such threat, we can take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- When situations like those above arise, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosures to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in your professional record. Your professional record might include information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any evaluations or professional consultations, your billing records including reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and/or others, or where information has been supplied by others confidentially, you may examine and/or receive a copy of your professional record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist. We charge a copying fee of $0.50 per page.

PATIENT RIGHTS

You have the Right to Request Restrictions on certain uses and disclosures of PHI. This request may or may not be honored and will be at the discretion of the treating psychologist.

You have the Right to Receive Confidential Communications by Alternative Means and at Alternative Locations (For example, you may not want a family member to know that you/your child is being seen at Agape Psych Services).

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents or legal guardians to examine their child's treatment records. Because privacy in

psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records.

If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern.

Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have. We understand that as a parent, you are concerned and may want to know about the content of your child's discussions. It is our experience that a child will progress better in treatment if they know their parent will not know the specific content of the therapeutic discussions. Many times, this is not due to the child wanting to "keep secrets" from the parents, but due to the child being embarrassed, guilty, or otherwise lack the communication skills.

RESTRICTION & CHANGES to PRIVACY POLICY

Restriction: In the case of a minor child/adolescent, the minor's legal guardian has the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about the child for as long as the PHI is maintained in the record. However, psychotherapy notes including statements made by a minor during therapy sessions will not be released, in order to protect the minor's right to confidentiality, unless required by law or deemed by the treating psychologist to be in the best interest of the minor.

Restriction: In most cases, we are also prohibited by law from disclosing raw psychological test data and test materials to anyone other than a licensed psychologist qualified to interpret such data.

QUESTIONS & COMPLAINTS

If you have questions about this notice, disagree with a decision that has been made about access to your records, or have other concerns about your privacy rights, please discuss this with your treating provider. It is also recommended that such inquiries be done in writing and mailed to the office address for record-keeping purposes. If you believe that your privacy rights have been violated and wish to file a complaint against your treating provider, you may send a written complaint to the office address. You may also make a formal ethics complaint to the American Psychological Association.

To do so, send the name of the treating provider, your name and address, and a statement about the reason for filing a complaint to APA – Office of Ethics, 750 First Street, NE, Washington, DC, 20002-4242.

You have specific rights under the Privacy Rule. There will not be retaliation against you for exercising your right to file a complaint, in accordance with the provisions of applicable law.

These HIPAA policies went into effect June 1, 2004.

INTERNS & PRACTICUM TRAINEE

Agape Psych Services is committed to providing training opportunities. Our licensed professional counselor interns (LPC-Intern), residents, and practicum trainee are able to provide quality counseling at a

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reduced rate or at times no cost. Your counselor intern has completed a master's degree in counseling from an accredited graduate school and has passed the Texas State Board of Exam for Licensed Professional Counselors. Practicum trainees and residents are enrolled in master's or doctoral degree programs and are obligated to practice under the same ethical guidelines as fully licensed clinician.

A Licensed Professional Counselor or Licensed Psychologist, who has additional training and is licensed by the State of Texas to do so, oversees all counseling cases. The supervisor will periodically review and discuss your counseling sessions to make sure you receive the best care possible. This review may include discussion, notes and constructive feedback with your counselor intern or practicum trainee of any topics discussed in your counseling session. If a session has been audiotaped (with your knowledge and permission) the supervisor will also be listening to the audiotape.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND UNDERSTAND/AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

_____ _____

Print name Date

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Signature of Therapist Date

The following signature indicates a willingness for private health information to be published with effort to diminish identifiable information for research purposes.

_____ _____

Signature of Client or Legal Guardian Date