tel: 281.783.9394
web. Finding You Counseling.com
email: GetHelp@FindingYouCounseling.com

(If possible please complete these forms PRIOR TO our first session so we can get started right away with your therapy. You can print and bring them to your first session. I will be happy to answer any questions you may have.)

PROFESSIONAL SERVICES AGREEMENT

We are pleased that you have chosen Finding You Counseling. This form gives you some information about our professional relationship. Your appointment is with Jessica Cooper, MSW, LCSW. You can read more about Jessica here http://www.findingyoucounseling.com/about-jessica.html. You are encouraged to ask her any questions regarding her background, credentials, professional experience, or philosophy.

CONFIDENTIALITY INFORMATION

Finding You Counseling is concerned about confidentiality. We work to provide an environment in which you place your trust and confidence. Under both federal and state law, confidentiality means communication with your therapist and any records pertaining to your identity, evaluation, or treatment will be held in confidence. Where federal and state laws differ, we comply with the stricter standard to ensure that your right to confidentiality is respected at all times. Also, beyond the law, we know that a sense of safety and security are necessary to the process of healing in which you are engaged. Finally, we are happy to honor your written wishes to release information to parties you choose, but cannot be held liable for the distribution of that information once it has been sent. By complying with federal and state laws, Finding You Counseling will maintain confidentiality to the fullest extent personally and professionally. You have a right to confidentiality.

Please read the document before signing this agreement

If you believe the Confidentiality Policy and Privacy Practices document does not answer all of your questions regarding confidentiality, talk with your therapist about any concerns you may still have. Your signature at the end of the document indicates consent to use your personal health information for routine practices according to the law for treatment, payment, and health care operations. You may revoke this consent in writing at any time, except to the extent that Finding You Counseling has taken action relying on this consent.

RIGHTS AND RESPONSIBILITIES

Rights

You have the right to be provided with professional and respectful care. You have the right to know your therapist's assessment of the problem, the recommended treatment, and resources available to help deal with your situation. You also have the right to refuse our suggestions.

Responsibilities

1. To be open, honest, and willing to share your concerns
2. To ask questions when you do not understand or need clarification

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3. To discuss any reservations you have about your treatment plan
4. To follow agreed upon treatment plan
5. To report changes or unexpected events related to your problem
6. To keep appointments whenever possible or to call and cancel within 24 hours prior to your appointment. (see payment information – you will be charged a $25.00 fee for appointments not cancelled with 24-hour notification unless you and your therapist have a previously agreed upon alternative fee)

Remember, you are responsible for your thoughts, feelings, actions, and growth. We are here to help facilitate that growth to the best of our ability

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PAYMENT INFORMATION

The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professional services. I require my clients to pay for the session prior to each meeting. You can do this via the PayPal link on the website, or in office (if applicable) before the start of our session. The financial investment for your counseling is:

- $125 for 50 minute face-to-face office visits
- $110 for 50 minute online therapy
- $145 for 50 minute on-site face-to-face visits, plus the cost of mileage from my office to your home or office. This amount (for milage) will be invoiced to you after your appointment.
- $75 for 50 minute phone therapy session
- $50 per e-mail therapy transaction (from you to me & me to you= 1 transaction)
- $65 per 30-minute "Intensive Session".

Please visit http://www.findingyoucounseling.com/work-with-me.html for a detailed description of each session.

As a courtesy, Finding You Counseling will file your insurance claims with your signed consent. Finding You Counseling also charges for missed appointments. Finding You Counseling charges a $25.00 fee to your credit card for appointments that are not cancelled with 24-hour notification. Each of these payment requirements are discussed below.

Insurance

Finding You Counseling does not participate on any insurance panels, and is there is unable to receive insurance reimbursements.

Financial Payment Arrangements

There is a $35.00 service charge for returned insufficient fund checks.

Appointment Cancellation Policy

Twenty-four hour (24) notification is an expected courtesy to the therapist who is reserving time for you and to other clients who are waiting to schedule appointments. You must give 24 hour advance notification for cancelled appointments. The advance notice is standard in our profession.

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If you miss an appointment without 24 hour notification, you will be charged the $25.00 fee. If you do not notify us 24 hours in advance when cancelling an appointment, you will be charged the $25.00 fee.

Finding You Counseling has a 24 hour voicemail system to assist you in cancelling appointments in a timely manner. Please leave the time of your call as part of your voicemail message in order to make sure that you are not charged when you have given 24 hour notification.

1. If you have a card on file, your card will be charged the $25 fee for the missed appointment.
2. If not, you will receive written notification of the missed appointment and a bill for the agreed upon amount within a few days of the previously scheduled appointment time. If you think there is an error, contact our office immediately.
3. You must pay for the missed appointment charge in full before or at your next scheduled visit.
4. Payment must be timely or we CANNOT continue to schedule appointments.

SIGNATURE FOR PROFESSIONAL SERVICES AGREEMENT

I do voluntarily agree to participate in the assessment and counseling as offered by Finding You Counseling. I am aware that treatment often education which will be recommended if the therapist deems it important to the healing process. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in this document.

I consent to the use of my personal health information for routine practices for treatment, payment, and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality Section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices Brochure.

I have been offered a copy of this packet.

I have read and agreed to the payment information as stated in this document.

I understand I may be charged for appointments that are not cancelled within 24 hours or for appointments I miss altogether.

By my signature below, I accept all terms and conditions as herein stated.

Client's Name _____

Client's Signature _____ Date _____

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Credit Card Authorization

(All clients must have credit card on file to receive services at this office.)

It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged $25. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/chargebacks.

I, _____, hereby authorize Finding You Counseling to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone and email consultations
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover ____ American Express

Card # _____ Expiration Date: _____

Name as printed on card:_____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing Finding You Counseling to bill my credit card at the usual fee for professional services. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Signature: _____ Date: _____

Print Name: _____

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CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Other concerns and issues." You may add a note or details in the space next to the concerns checked.

	I have no problem or concern		Headaches, Pains		Relationship Problems
	Abuse – emotional		Health		Re-marriage
	Abuse - neglect		Hostility		Risk Taking
	Abuse – physical		Impulsive Spending		Sadness
	Abuse – sexual		Impulsiveness		School Problems
	Aggression		Indecision		Self-abuse – burning
	Anger		Inferiority Feelings		Self-abuse – cutting
	Anxiety		Inhibitions		Self-abuse – other
	Arguing		Interpersonal Conflicts		Self-abuse – scratching
	Attention Problems		Irresponsibility		Self-centeredness
	Career Concerns		Irritability		Self-control
	Childhood Issues		Judgment Problems		Self-esteem
	Children – care of		Laziness		Self-neglect
	Children – custody		Legal Matters		Separation
	Children – management		Loneliness		Sexual Conflicts
	Codependence		Loss of Control		Sexual Desire Differences
	Compulsive Spending		Losses		Sexual Dysfunction
	Concentration Problems		Low Energy		Sexual – other issues
	Confusion		Low Frustration Tolerance		Shyness
	Crying		Low Income		Sleep – insomnia
	Deaths		Low Mood		Sleep – nightmares
	Debt		Marital Coldness		Sleep – too little
	Decision Making		Marital Conflict		Sleep – too much
	Delusions – false ideas		Marital Distance		Step-parenting
	Dependence		Marital Infidelity/Affairs		Stress
	Depression		Medical Concerns		Stress-management
	Distractibility		Memory Problems		Suicidal Thoughts
	Divorce		Menopause		Suspiciousness
	Drug abuse – over the counter		Menstrual Problems		Temper Problems
	Drug abuse – prescription		Mixed Feelings		Tension/Stress
	Drug abuse – street drugs		Mood Swings		Thought Disorganization
	Drug abuse – alcohol		Motivation		Threats of Violence
	Eating – poor appetite		Mourning		Tiredness
	Eating – making myself vomit		Obsessions		Tobacco Use
	Eating – overeating		Outbursts		Violence
	Eating – under-eating		Oversensitive to Criticism		Violence – victim of crime
	Emptiness		Oversensitive to Rejection		Work Problems
	Failure		Panic or Anxiety Attacks		Weight and Diet Issues
	Fatigue		Parenting		Withdrawal – isolating
	Fears		Perfectionism		Employment Problems
	Financial Troubles		Pessimism		Employment – lack of
	Friendship Problems		Phobias		Employment – overdoing
	Gambling		Physical Problems		Employment – termination
	Goals Not Being Met		PMS		**Other Concerns or Issues:**
	Grieving		Poor Self-Care		

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	Guilt		Procrastination		

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: *This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

COUNSELING DETAILS

Briefly describe your current difficulty: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your goals you hope to achieve through counseling?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Have you ever been to counseling before? YES ____ NO ____ Support/Recovery Groups: YES ____ NO ____

If yes, identify counselor and the dates:

_____

_____

Have you ever been hospitalized for mental health reasons? YES ____ NO ____

If yes, when, where, and why were you hospitalized?

_____

_____

Briefly explain the nature and outcome of that counseling:

_____

_____

_____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY: _____

_____

_____

_____

_____

_____

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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 it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care options.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested

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restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice on our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Finding You Counseling, LLC
123 Northpoint Dr.
Houston, TX 77060
281.738.9394

For more information about HIPAA
or to file a complaint:
US Dept. of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll Free: 1-877-696-6775

tel: 281.783.9394
web. Finding You Counseling.com
email: GetHelp@FindingYouCounseling.com

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name:
Signature:
Date:

OFFICE USE ONLY

_____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

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PERSONAL INFORMATION SHEET

Please fill out this form as completely as you can and all information will be held in the strictest confidence.

CLIENT INFORMATION:

Name: _____ Birth date: _____/_____/_____

Address: _____ City: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Sex: ____ M ____ F Marital Status: _____

Is email an acceptable form of communication with you? Yes _____ No _____

Are calls at work an acceptable form of communication with you? Yes _____ No _____

RESPONSIBLE PARTY INFORMATION:

Name: _____

Relationship to client: ____Self ____Spouse ____Child ____Other (Please specify): _____

Address: _____ City: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

As the responsible party:

1. I accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made.
2. AUTHORIZATION FOR RELEASE: I hereby authorize the release of any information regarding my condition or treatment to insurance company (if applicable).

SIGNATURE: _____ DATE: _____