EMPOWERED LIFE COUNSELING, PLLC

Counseling Informed Consent

_____ Initial

CONFIDENTIALITY: Everything you say is these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law.

_____ Initial

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the you present a danger to others. Disclosure may also be required by the courts.

_____ Initial

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

_____ Initial

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call (918) 991-5538. If I do not answer, I will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message. If you need to talk to someone right away, call 911 or go to your nearest emergency room.

_____ Initial

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include EMDR (Eye Movement Desensitization and Reprocessing) Cognitive/Behavioral, Psychodynamic, Family Systems, or Play Therapy. I do not prescribe drugs.

_____ Initial

APPOINTMENTS: When you make an appointment, a specific time is reserved for you. If you are late to your appointment, ***you will be seen for the remaining portion of your reserved time.*** If your appointment starts late because of therapist, you will be seen for your full visit.
I am financially responsible for my attendance at all scheduled appointments, unless cancelled with at least 24-hour notice. **Minimum charges of $50 will be applied to my account for a late cancel and $85 for a no-show.** ***This charge is NOT covered by insurance.***

_____ Initial

TERMINATION: ***Treatment is intended to continue until your goals are met.*** If you feel you are not making progress during treatment, it is important to discuss your concern with your therapist. It is possible you may need to be referred to another provider who could better meet your needs. Your therapist will discuss the end of therapy with you when you appear to be close to meeting your goals. You have the right to end therapy at any time.

_____ Initial

DUAL RELATIONSHIPS: "Dual relationship" refers to any relationship between you and your therapist that is not a client-therapist relationship. Not all dual or multiple relationships are unethical or avoidable. Therapy should not involve any relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will not publicly acknowledge working with you without your written permission. I will not accept you if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

I have read the above policies. I understand them and agree to comply with them.

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications/ Text Messaging

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Choose ONE:

_____I prefer to receive unencrypted email communications.

_____I prefer to receive encrypted emails, that require a password to access.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

I have read the above policies. I understand them and agree to comply with them.

Client Signature _____ Date _____

For further information regarding this notice, please contact Empowered Life Counseling at 918-991-5538.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. Psychotherapy contact notes are not available for the patient to review. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below. You may revoke that permission, in writing, at any time.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient Date

For further information regarding this notice, please contact Empowered Life Counseling at 918-991-5538.

EMPOWERED LIFE COUNSELING, PLLC

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY & Credit Card Guarantee Form

FINANCIAL POLICY

Fees. Counseling sessions are 50 or 90 minutes long

Initial Assessment: $150

Ongoing Therapy: $150 for 50 minute session $225 for 90 minute session

Payment is collected at the first of the session. Payment is to be made by credit card, check, or cash at time of service.

Insurance Patients. Empowered Life Counseling accepts assignment of benefits as an in-network provider for BlueCross BlueShield and HealthChoice. You are responsible for your deductible and co-pay or co-insurance which is due at the time of your appointment. However, few policies cover 100% of the cost and collection of insurance claims is ultimately the insured client's responsibility, regardless of your in-network or out-of-network. **Please understand that you are fully responsible for the payment of all fees for services provided regardless of the extent of any insurance coverage you may have.** For out-of-network services, it is not my policy to accept the amount an insurance company may offer as payment, if the amount is less than the regular fee. Empowered Life Counseling will be notified of any personal address change or changes in insurance coverage.

Self-Pay Patients. Clients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. Empowered Life Counseling, PLLC accepts cash, checks, and major credit cards.

MISSED APPOINTMENT POLICY

Twenty-four-hour notice is required for the cancellation of an appointment. **Minimum charges of $50 will be applied to my account for a late cancel and $85 for a no-show. *This charge is NOT covered by insurance.*** Appointments missed because of inclement weather or other major problem will not be charged. Your charge will be applied to your credit card on file.

_____ I acknowledge that my credit card is kept on file with Empowered Life Counseling, PLLC.

I have read and agree to the above conditions.

_____ _____

Client signature Date

REV. 07/2017

Empowered Life Counseling, PLLC
5800 East Skelly Drive, Suite 105
Tulsa, Oklahoma 74135

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Client:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this client, but it could not be obtained because:

□ The client refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We weren't able to communicate with the client.

□ Other (please provide specific details) _____

_____

_____ _____
Therapist Signature Date