EMPOWERED LIFE COUNSELING, PLLC

Counseling Informed Consent

_____ Initial

CONFIDENTIALITY: Everything you say is these sessions and the written notes we 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 we become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, we will do whatever we 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, we may also contact the person whose name you have provided on the biographical sheet.

_____ Initial

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact us between sessions, please call (918) 991-5538. If we do not answer, we 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. We want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and we 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. We are likely to draw on various psychological approaches. These approaches may include EFT (Emotionally Focused Therapy), EMDR (Eye Movement Desensitization and Reprocessing) Cognitive/Behavioral, Psychodynamic, Family Systems, CPP (Child Parent Psychotherapy) or Play Therapy. **WE DO NOT PRESCRIBE DRUGS.**

_____ Initial

APPOINTMENTS: I have read the Late Cancellation/Missed Session policy. I understand the policy and I agree to comply.

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 but you should discuss this decision with your therapist, so referrals can be made, if appropriate.

_____ 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. we will not publicly acknowledge working with you without your written permission. We will not accept you if we feel a significant dual or multiple relationship exists. It is your responsibility to advise us if any dual or multiple relationship becomes uncomfortable for you in any way. We will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find that it 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. we understand them and agree to comply with them.

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

Empowered Life COUNSELING

LATE CANCELLATION/MISSED SESSION POLICY

Effective January 1, 2020

A cancelled appointment hurts three people: you, your therapist, and another client who could have potentially used your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. In addition, we are unable to bill your insurance company for sessions that are not kept.

Without a cancellation fee policy in place, your therapist will lose money or the opportunity to schedule another client if you late cancel or do not show up.

Our cancellation policy is this: Clients can cancel or reschedule an appointment anytime, if they provide 24 hours' notice. If you cancel an appointment with less than 24 hours' notice, or fail to show up, you will be charged a $100 fee for the appointment.

Some practices have a 48-hour policy. Some even have a 72-hour policy. **Ours is 24 hours, and we are firm at 24 hours.**

Our cancellation policy in not a penalty or a punishment. Most clients understand this. Very rarely, there will be a client who will feel that he or she is being punished when they are charged a late cancellation fee. We want to make sure that you don't feel this way, if someday you miss an appointment. It is likely, if you are in counseling long enough, at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Maybe you'll need to work late. Maybe you'll get a sudden onset of the flu. Maybe your kids will have doctor appointments, or your car will break down, or something unavoidable will come up.

We are not upset with clients when they miss an appointment. We know that's life. In return, our clients understand that scheduling an appointment with one of us is like buying tickets to an event. If you miss the event, it doesn't matter why you missed it, or even if it was your first time, you can't turn in your tickets for a refund.

A fee of **$100** will be charged when you miss or cancel an appointment without giving **24 hours advanced notice.** This means that if an appointment is scheduled for 3:00 pm on a Tuesday, notice must be given by 3:00 pm on Monday **at the absolute latest.** ***For Saturday or Sunday appointments, 48-hour notice is required.** You can cancel your appointment by calling, texting, or emailing your specific therapist. If you are more than 15 minutes late to your appointment time, it will be treated like a late cancellation. It's important to remember that insurance will not pay for missed appointments, so you will be responsible for the full **$100 fee,** not just a co-pay.

The **only** time we will waive this fee is in the event of serious or contagious illness or extreme weather or other unavoidable circumstance. If you are unsure, please contact your therapist for further guidance.

Please understand that therapy should be viewed as any other important medical appointment would be viewed. This cancellation policy is important for our counseling practice because while a medical doctor can see 35 patients in a day, a therapist generally sees a maximum of 6 to 8 clients a day. We reserve for you a full hour of our time for the session and clinical notes. If a client cancels with less than a full 24-hour notice it is unlikely that we will be able to fill that time slot, and we lose an entire hour from our work schedule.

While it is a time commitment, this is for your personal growth and consistency is key in order to achieve this. If you miss **three** scheduled appointments within a **six-month** time period without cancelling or rescheduling in accordance with cancellation policy of 24 hours' advance notice, the therapeutic relationship will be terminated and appropriate referrals to other practices will be offered. **Clients who are unsure if they can commit to therapy appointments scheduled for them should seek services elsewhere.**

You may return to therapy at any time should you so choose; however, you may be placed on a waiting list if your therapist doesn't have openings on their schedule at the time. This is standard practice with most therapy agencies and private practice offices.

Because your therapist believes that the responsibility for your care is on both the client and the therapist, we agree that if you are double-booked for an appointment or if we miss an appointment without notice you will receive a FREE therapy session.

I have read the above policy. I understand the policy and I agree to comply.

Client's Signature _____ **Date** _____

Therapist's Signature _____ _____

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we 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 our 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 your therapist.

Email Communications/ Text Messaging

We 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 our 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 unless you opt for encrypted email communication. 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

Initial Acknowledgement:

_____ I acknowledge that I will receive a reminder text for appointments **and will confirm upon receipt of text.**

Initial ONE Option:

_____ I prefer to receive unencrypted email communications.

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

Social Media

We do not communicate with, or contact, any of our clients through social media platforms from our personal accounts. We participate on various social networks, in both personal and professional capacities. If you have an online presence, there is a possibility that you may encounter our personal accounts by accident. If that occurs, please discuss it with us during our time together. We believe that personal communications with clients online have a high potential to compromise the professional relationship. However, if you would like to follow our Empowered Life Counseling Facebook or Instagram accounts, feel free. We post inspirational and helpful items to these accounts that may be motivational or helpful to you.

Websites

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

Web Searches

We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about me in this way. Currently 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.

Monthly Email Newsletter

*<initial here>*_____ I would like to opt-in to the Empowered Life Counseling newsletter that is sent via email each month.

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.

Rev. 01/2020

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 55 or 90 minutes long

Initial Assessment: $150

Ongoing Therapy: $150 for 55-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, Cigna, United Healthcare/Optum/UMR, QuikTrip Insurance/Care ATC, PHCS/Multiplan, HealthCare Solutions Group 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 our 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. **If you cancel an appointment with less than 24 hours' notice, or fail to show up, you will be charged a $100 fee for the appointment.** ***This charge is NOT covered by insurance.*** Your charge will be applied to your credit card on file. Appointments missed because of serious or contagious illness or extreme weather or other unavoidable circumstance will not be subject to this fee.

*<initial here>*_____ 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. 01/2020

Empowered Life Counseling, PLLC
4157 S. Harvard Avenue, Ste. 118
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