

Progressive Counseling & Consulting, LLC

Angela M. Powell, MA, CART, LPC

4830 Wilson Rd., Suite 300 #11 • Humble, TX 77396

(713) 344-1701 fax • (713) 705-0545 cell

angela@houstonprocounseling.com

INFORMED CONSENT

Thank you for choosing Progressive Counseling & Consulting, LLC. Your appointment will take approximately 45 – 50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. Angela Powell, LPC has earned a Bachelor of Psychology Degree from the University of Houston – Downtown and a Masters Degree in Counseling from Prairie View A & M University. I am licensed by the State of Texas as a Licensed Professional Counselor. I practice standard play therapy for children and innovative therapy for most conditions. Other treatment approaches may be used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you prior to your session.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this to the Texas Department of Family and Protective Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. I will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ ***Date:*** _____

FINANCIAL/INSURANCE ISSUES: As a courtesy I will bill your insurance company, HMO, responsible party or third party payer for you if you wish. I ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not

cover counseling, I request that you pay the balance due at that time. If your balance exceeds \$300.00 payment will be due when services are rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. I ask that every client authorize payment of medical benefits directly to Progressive Counseling & Consulting, LLC.

I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

You may have a copy of this form if requested.

Signature(s)*_____ ***Date_____**

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent no information will be shared.

____ You may inform my physician ____ I decline to inform my physician

PHYSICIAN

NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s)*_____ ***Date_____**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ maybe treated as a client by Angela Powell. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

Signature(s)*_____ ***Date_____**

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HIPPA 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.

Effective date: December 4, 2008

Angela Powell is committed to maintaining clients' confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of your healthcare information.

Usage and disclosure of your health information for the purposes of providing services.

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes.

TREATMENT I may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS I may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent.

There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse, information that informs me that you are in danger of harming yourself or others, information shared with law enforcement if a crime is committed on the premises or against me or as required by law such as a subpoena or court order. In these instances, by Texas State Law, I am obligated to report to the appropriate authorities.

Client Signature

Date

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CLIENT RIGHTS

Right to request how we contact you.

It is normal practice to communicate with you at your home address and daytime phone number you provided when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes I may leave messages on your voicemail. You have the right to request to be contacted in a different way.

May I contact you at home? (circle one) **yes no** May I contact you at work? **yes no**. May I contact you by cell phone? **yes no** Where may I contact you? _____

Right to release your medical records.

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in medical records. To request access to your billing or health information, contact the office. Under limited circumstance your request may be denied to inspect and copy. If you ask for a copy of any information, there may be a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend the record. I will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstances, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact the office. You must submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You may request an accounting of any disclosures, if any, I have made related to your medical information, except for information used for treatment, payment, or health care operational purposes or that I shared with you or your family. This excludes information I am required to release.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to the office. However, I am not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office.

Client Signature

Date