INFORMATION, CONSENT, AND POLICIES

This form is intended to outline the applicable information, consent, and policies of services. If there are questions or concerns you have regarding any of the information, please feel free to ask at your initial intake or any time after. I am glad you are here and feel honored that you have chosen me to join you on your path toward healing.

My journey into psychotherapy began in 2019 at the University of Mary Hardin-Baylor, where I earned my Bachelor's degree in Psychology. I then pursued a Master's degree in Marriage, Family, and Child Counseling, completing my graduate studies in 2022. I chose the LMFT route because of its strong emphasis on a systemic and relational approach. This approach closely aligns with my conceptualization of people and the world. I see us as deeply interconnected, shaped by the relationships and systems that influence our lives. Since completing graduate school, I have obtained my license to practice as an LMFT. Additionally, I had the privilege of working at a nonprofit organization, where I supported children and families facing a wide range of challenges across various life stages and cultural backgrounds. This experience deepened my understanding of diverse client needs and strengthened my commitment to compassionate, individualized care. In early 2024, I launched my own practice to broaden my reach and create new opportunities to support more clients on their healing journeys.

The process of psychotherapy begins with the deep human desire for change. People seek counseling when life feels disrupted, old patterns unravel, or emotional pain becomes overwhelming. These challenges invite reflection and healing. Therapy provides a safe, compassionate space to explore our inner world, our thoughts, feelings, histories, and relationships, leading to insight, clarity, and transformation. Along the way, we often uncover old wounds that can bring discomfort and strain, but this discomfort signals growth and the creation of healthier ways of being. My role is to walk alongside you, offering support and a judgment-free environment where you can face difficult truths with courage and discover your resilience within. Together, we will navigate your unique journey, honoring both pain and hope. Though therapy can be challenging, it is also a powerful process of bravery, vulnerability, and renewal.

If you are an adult or couple receiving services, I kindly ask that you refrain from bringing children to your therapy sessions. This helps maintain a focused and uninterrupted therapeutic environment, allowing us to fully engage in the work at hand. Additionally, the therapeutic relationship is a unique and powerful connection, built on trust, empathy, and mutual respect. However, it is essential to understand that this relationship is strictly professional not personal. While therapy may involve deep emotional exploration and a strong sense of connection, the boundaries that define the therapeutic space are intentional and necessary. These boundaries exist to protect the integrity of the work we do together. It is important to note; clients have the right to terminate counseling at any time. I respect client's decisions to terminate and just ask that a notification of termination be given to conclude services effectively. Finally, I am governed by the Code of Ethics of the Texas State Board of Examiners of Marriage and Family Therapists. Should you have complaints, please submit those to this board by telephone at 1-800-821-3205 or in writing at bhec.tx.gov.

OFFICE POLICIES

FEE SCHEDULE:
Standard rate: $180.00 per standard 50-minute session.
After Hours rate: $210.00 per session
Cash, credit cards, and personal checks are accepted. This rate also applies to other professional services, prorated based on $180.00 per hour. These services include, but are not limited to, phone calls, insurance reports, third-party consultations case reviews, and correspondence.

PAYMENT POLICY:
Payment is due in full at the time of service. Please make out your check before the session begins. Checks should be made out to: Woodlands Family Institute (or WFI). Cash and Visa or MasterCard are also accepted. It is not my policy to carry balances forward. I expect balances for "forgotten checkbooks" or forgotten appointments to be made up promptly or by the next scheduled appointment at the latest. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency which will impact your credit rating.

_____Initials indicating you have read and understand payment policy and fees

Medicare: None of the counselors/therapists at Woodlands Family Institute, P.C. are Medicare providers. All clients on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" to receive services at our practice. All services must be paid at the time of service, and neither WFI, its counselors/therapists, nor the client may file a claim to Medicare for reimbursement.

Are you on Medicare or Medicare Eligible? ☐ **Yes** ☐ **No**
If yes, please notify your counselor/therapist **BEFORE** your first session so you can sign the Medicare Opt Out Private Contract. **This is required for all Medicare or Medicare Eligible clients.**

Medicaid: We are not accepting any Medicaid patients; we will only accept "Private Pay" patients.

We will not file any claims to Medicaid or Medicare for reimbursement of your medical services now or at any time in the future.

_____Initials indicating you have read and understand the information regarding Medicare/Medicaid

Legal Testimony:
Please be advised that I **do not** provide consultation, evaluation, or legal expert testimony in child custody, child visitation, or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $800 per hour, portal to portal. This fee will apply to depositions or interrogatories as well. Record review, consultation with clients, litigants, attorneys (in person or via phone or email), reports, waiting at court, or any other service provided will be charged at the rate of $180 per hour or prorated accordingly. These fees are **payable in advance.**

_____Initials indicating you have read and understand the information regarding Legal Testimony

INSURANCE:
I am not a participating provider for any insurance carriers. We will provide you with an insurance-ready receipt that you can use to file for out-of-network benefits. Reimbursement will depend on your insurance plan.

_____Initials indicating you have read and understand the information regarding insurance

MY OFFICE HOURS:
I currently see clients on Monday, Tuesday, or Wednesday by appointment only unless otherwise specified.

CANCELLATIONS:
Since the scheduling of an appointment involves the reservation of time specifically for you, 24-hour advance notice for any canceled appointments will not be charged. If you are unable to meet this time schedule, but if I am able to assign your appointment time to another client, you will not be charged. If the session cannot be filled, or if you are a "no show," you will be charged the full rate of the session. Please note that insurance companies do not reimburse for missed appointments. **Please call WFI at: 281-363-4220 for cancellations, as email is not monitored daily for cancellations.**

_____Initials indicating you have read and understand the cancellation policy

EMERGENCIES:
It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for client's day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message at 281-363-4220 making sure to state that your call is an emergency. I will respond to your call as promptly as possible. If I am unable to respond quickly enough, please call 911 or go to your local emergency room. Please also be advised that you can call or text 988 for a counseling crisis as well if I do not respond in enough time.

TELEHEALTH SERVICES:

Telehealth, also known as distance counseling, involves the delivery of mental health services using secure video, phone, or other electronic means. Telehealth services are not the same as in-person therapy. Telehealth may involve the use of technology such as video conferencing, phone calls, or secure messaging. I will use the HIPAA compliant platform, SimplePractice, to conduct telehealth sessions.

TECHNOLOGY REQUIREMENTS AND SECURITY:

The client is responsible for providing the necessary technology (internet, webcam, etc.) and ensuring sessions are held in a private and secure location. SimplePractice is encrypted and complies with HIPAA privacy and security standards. I value the safety and privacy of clients and have taken reasonable steps to ensure that protected health information (PHI) is secure.

RISK AND LIMITATIONS:

Telehealth may involve the disruption of services due to technical difficulties, such as poor connection, etc. Client PHI can be overheard if the client is not in a private location when participating in distance counseling services. Additionally, possible unauthorized access to PHI may occur if clients do not ensure privacy on their end. Finally, if clients are traveling outside of Texas, services cannot be rendered until the client returns to the state. I will take steps to reduce these risks, but clients must acknowledge that no technology can guarantee full confidentiality.

EMERGENCY PROTOCOLS:

Due to the therapist and client not physically being present with one another, clients must inform their therapist of their physical location at the beginning of each session. Clients must also provide the name and contact information of an emergency contact and their local emergency services. In the case of an emergency or disconnection during a crisis, the therapist may contact the emergency contact or call local emergency services to ensure the client's safety.

CLIENT RIGHTS AND RESPONSIBILITIES:

Clients have the right to refuse or withdraw consent for telehealth at any time. Additionally, clients have the right to ask questions about the procedures, risks, and alternatives. Clients are responsible for ensuring a safe, private environment during sessions.

_____Initials indicating you have read and understand the telehealth policies, risks, emergency protocols, and client rights and responsibilities

CONFIDENTIALITY:

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. Your signature on the Acknowledgement form provides consent for those activities, as follows:

Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's

identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not be ordinarily mentioned in our sessions unless it seems important to our work together. If you would prefer this to be handled differently, please let me know.

While I do all that I can to protect confidentiality during correspondence, please be aware that through the use of technology (email, cell phones, voicemail, texts, Zoom, etc.) neither you nor I can completely guarantee total privacy/confidentiality.

To help maintain confidentiality, it is important that you, as the client, agree not to video or audio record our sessions.

If you request that we have a session outside of the office for any reason, please be aware that complete confidentiality cannot be guaranteed.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else and sign a release of information form; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about one's physical, emotional, or mental condition; g) when disclosure is relevant in any suit affecting the parent-child relationship; h) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to third parties.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

_____ _____

Signature Date

Referred to our office by:_____

May we send a **thank you** to the person who referred you? ☐ Yes ☐ No

May we mention your **name** in that thank you? ☐ Yes ☐ No

Clients First name: _____ Clients Last name: _____

Age: _____ Birth Day: _____ Month: _____ Year: _____

Address: _____

Cell #: _____ Home #: _____

Email: _____

Preferred method of contact: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Consent for treatment for clients 18 & older: I give full consent for myself to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Name of client: _____ Signature: _____ Date: _____

Consent for treatment for clients 17 & younger:

I give full consent for my child to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. **For minors of parents who have an active custodial order/divorce decree in place: It is required by the Texas State Licensing board that a copy of the current custodial order/divorce decree be kept on file stating who has the authority for making mental health decisions for a minor. It will be necessary to provide this BEFORE your child's first session.**

Name of client: _____ Date of birth: _____

Name of parent/guardian: _____ Signature: _____ Date: _____

Name of parent/guardian: _____ Signature: _____ Date: _____

REQUIRED: We require that a credit card be kept on file for all sessions. If you wish to use a different payment method at the time of your appointment, please notify the front desk before your session begins. This card will also be used for all after hours appointments, telehealth appointments, missed appointments or late cancel appointments.

Cardholder's Name _____ Relationship _____

MC/VISA/DISC No. _____ Exp. Date _____

Signature of Authorized User _____

Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer-generated voice mail message), the day before your scheduled appointments.

Your name: _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

☐ Via text message on my cell phone (normal text message rates will apply)

☐ Via email message to the address listed above

☐ Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Darya Ross Counseling, PLLC and/or WFI may *use* or *disclose* your *protected health information (PHI)* for *treatment*, *payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*": *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of *treatment* would be when I consult with another health care provider, such as your family physician or a colleague. *Payment* is when I obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within the practice of Darya Ross Counseling, PLLC such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of the practice of Darya Ross Counseling, PLLC, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (Of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to me any situation that constitutes sexual misconduct by a current or former therapist, then I am required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to the complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and My Professional Duties

Client's Rights:

- *Right to Request Restrictions*-You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking my services. Upon your request, I will send bills or other correspondence to another address.)
- *Right to Inspect and Copy*-You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may

deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend*-You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting*-You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of the Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*-You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically. My Professional Duties:
- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.
- If I revise the policies and procedures, I will post a current copy in my office. You may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (281) 363-4220 if you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Miranda Butler at: 10200 Grogans Mill Road, Suite 550, The Woodlands, Texas, 77380. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

NOTICE TO CLIENTS: The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council, George H.W. Bush State Office Building, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701. Telephone (512)305.7700 or 1.800.821.3205

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice goes into effect 4/1/2011. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice upon request, and it will be posted in the office.

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____ _____

Client or Authorized Representative Signature Date

☐ Refuse to Sign ☐ Unable to Sign (specify reason) _____

Individual Intake Form

Contact Information:

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Preferred method of contact?

- ☐ Phone
- ☐ Email
- ☐ Either

Demographic Information:

Gender: _____ Ethnicity: _____ Relationship Status: _____

Sexual Orientation: _____ Faith Orientation: _____

Presenting Issue:

Please briefly describe what is bringing you in:

_____
_____
_____
_____
_____

When did these concerns begin:

_____

Any other current stressors:

_____

Please name one or two goals you would like to achieve during your time in counseling:

- Goal #1: _____
- Goal #2: _____

List your resources for support (ex: family, friends, groups, community resources, etc)

- _____
- _____
- _____
- _____

Mental Health History:

Is there a known history of mental health concerns that run in your family?

- ☐ Yes
- ☐ No

- If yes, what?

  _____

Have you ever been seen by a psychiatrist or mental health provider before?

- ☐ Yes
- ☐ No

Who was your most recent psychiatrist and/or counselor ? _____
What was the duration of treatment? _____
Was any medication prescribed?_____

Physical Health:

Do you have any medical diagnoses or concerns that I should know about as it relates to your physical health?

_____
_____
_____

Are you taking any medications?

_____

Substance Use Survey:

How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Once a month
- ☐ A couple times a month
- ☐ A couple times a week
- ☐ Almost every day

Do you use drugs recreationally?

- ☒ Yes
- ☐ No

- If yes, what type/quantity/frequency?

  _____

Safety Assessment:

Have you thought about hurting yourself or others in the last two weeks?

- ☐ Yes
- ☐ No

Referral Source:

How did you hear about me?

_____

Printed Name: _____

Signature: _____ Date: _____