INFORMATION, CONSENT, AND POLICIES

I am honored you have asked me to help you by providing counseling services. I will do everything I can to make this experience as meaningful and fruitful as possible. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a Master's Degree in Clinical Mental Health Counseling and I have been a Licensed Professional Counselor since 2023. I believe that no matter how difficult a person's circumstances may be, it is possible to produce meaningful changes. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or even years. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or to assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying. I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you. I am an employee of Darya Ross Counseling, PLLC, and an associate of Woodlands Family Institute, P.C.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we can concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to me, I request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

OFFICE POLICIES

FEE SCHEDULE:
Standard rate: $160.00 per standard 50-minute session.
Accelerated Resolution Therapy (ART): $200.00 per 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 $160.00 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 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 $160 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 Tuesday, Thursday, and Friday 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 understand 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.

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.

In the event, that I should die or become incapacitated during our work together or after, an arrangement has been made for another Licensed Professional Counselor whom I trust greatly to take over and maintain all of my records/files. Her name is: Alicia Gregg, MA, LPC. This is done to maintain the integrity of the mental health records.

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.

CLIENT INFORMATION

First name: _____ Last name: _____

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

Home address with postal code: _____

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 _____

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

{Please refer to pages 7-9 of this document}

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) _____

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 Darya Ross Counseling, PLLC at: 1610 Woodstead Court, Suite 420, 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.

PSYCHOSOCIAL HISTORY

Date _____

Name of Patient:_____ Date of Birth: _____

Presenting Problems:

____Recent life transition
____Depression, isolation, withdrawal
____Suicide gesture, attempt or ideation
____Homicidal ideation
____Self-abusive behavior
____Abuse (physical, emotional, sexual)
____History of traumatic life events (in addition to the previous)
____Neglect, abandonment
____Marginal to low IQ
____Difficulty at school or work
____Difficulty with authority
____Commits unlawful acts
____Under socialized (difficulty making friends)
____Anger outbursts/rage
____Runaway from home or placement
____Impulse control problems
____Low self-esteem
____Physically aggressive
____Destruction of property
____Sexual dysfunction
____Does not feel guilty about wrongdoing
____Paranoid thoughts, delusions
____Hallucinations (auditory, visual, tactile)
____Gender identity problems
____Excessive worry, racing thoughts, obsessions
____Compulsive behavior
____Substance abuse

When did these problems start? _____
What makes these problems worse?_____
What makes these problems better? _____
Have you had any **treatment** for these problems before today? ☐ Yes ☐ No
If yes, when? Where? Who was your doctor or therapist?

_____

_____

Psychiatric History

Have you ever had thoughts about wanting to hurt yourself or end your life? ☐ No ☐ Yes
If yes, please describe (when, plan, action, etc.):

_____

_____

Are you currently experiencing any thoughts of suicide or self-harm? ☐ No ☐ Yes
If yes, please describe (plan, action, how often, etc):

_____

_____

Have you ever had thoughts about wanting to hurt or end someone else's life? ☐ No ☐ Yes
If yes, please describe (when, plan, who, action, etc.):

_____

_____

Are you currently experiencing any thoughts of homicide or harming someone else? ☐ No ☐ Yes
If yes, please describe (when, plan, who, action, etc.):

_____

_____

History of psychiatric hospitalizations

Date_____Location_____Outcome_____

Date_____Location_____Outcome_____

Date_____Location_____Outcome_____

Family past psychiatric history

_____

_____

_____

Family medical history

_____

_____

_____

Personal past medical history

_____

_____

_____

Drug and Alcohol Abuse

Any **family** history of drug and/or alcohol usage? Please list and describe _____

_____

_____

_____

Any **personal** history of drug/alcohol usage? List and describe _____

_____

_____

_____

Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)

Name	Relationship	Age	Living where?

Marital status of patient

Married _____ How long_____

Divorced _____ How long ago _____

Separated _____ How long ago _____

Widow/widower____ How long ago _____

Other _____

Other significant adults or children in patient's life
(Please include type of relationship-e.g. supportive, conflictual, etc.)

_____

_____

_____

Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?

Please briefly describe _____

_____

_____

_____

Any history of significant life events such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

_____

_____

_____

_____

Cultural Influences

With what ethnic/cultural groups do you personally identify? _____

With what ethnic/cultural group does your family most identify? _____

Describe any cultural values or beliefs that may impact treatment _____

_____

Educational History

Highest degree earned_____

Current School attending_____ Grade_____

Average grade performance _____

Overall motivation to attend school _____

Extracurricular activities_____

Employment History

Present employment status-where-how long? _____

Positive/negative aspects of current position _____

_____

If on leave of absence or disability, will you return to present job? _____

_____

Special interests/hobbies/skills

_____

_____

Additional Comments _____

_____

_____ _____

Signature Date