



NOTICE OF PRIVACY PRACTICES

Revised 10/22/07

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

Counseling Center for Living Well, PLLC, uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. Your health information is contained in a treatment record that is the physical property of **Counseling Center for Living Well, PLLC**.

How Counseling Center for Living Well, PLLC, May Use or Disclose Your Health Information

For Treatment **Counseling Center for Living Well, PLLC**, may use your health information to provide you with treatment services. For example, information obtained by **Counseling Center for Living Well, PLLC** will be recorded in your record that is related to your treatment, which is necessary to determine what type of treatment you should receive. **Counseling Center for Living Well, PLLC**, will also record actions taken in the course of your treatment and note how you respond to those actions.

For Payment **Counseling Center for Living Well, PLLC**, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment.

For Health Care Operations **Counseling Center for Living Well, PLLC** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to evaluate quality care and outcomes, to learn how to improve the services or facilities, and determine how to continually improve the quality and effectiveness of the health care provided.

Appointments **Counseling Center for Living Well, PLLC** may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law **Counseling Center for Living Well, PLLC** may use and disclose information about you as required by law. For example, **Counseling Center for Living Well, PLLC**, may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties

Health and Safety Your health information may be disclosed to avert a serious threat or safety of you or any other person pursuant to applicable law.

Government Functions Specialized government functions such as protection of public officials or reporting various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **Counseling Center for Living Well, PLLC**, has taken action in reliance on such.



Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, **Counseling Center for Living Well, PLLC**, is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative location; and
- Receive an accounting of disclosures made of your health information.

Complaints

You may complain to **Counseling Center for Living Well, PLLC**, and the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Counseling Center for Living Well, PLLC,

Counseling Center for Living Well, PLLC, is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative location; and

Counseling Center for Living Well, PLLC, reserves the right to change information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request or at your next visit to the office.

Contact Information:

If you have any questions or complaints, please contact:

Counseling Center for Living Well, PLLC
Christina L. Russell, MA, LPC, NCC
10615 Perrin Beitel Rd., Ste. 207
San Antonio, TX 78217
(210) 490-9106

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257 Toll free 1-877-696-6775



COUNSELOR--CLIENT CONTRACT

Qualification/Experience:

This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have an M.A. in Counseling from the University of Texas at San Antonio. I am a Licensed Professional Counselor (# 17708) by the state of Texas. I am also a National Certified Counselor (# 91965) by the National Board for Certified Counselors. I use the skills and training of the Masters in Counseling degree and continuing education as well as Biblical knowledge through a daily relationship with Jesus Christ.

Nature of Counseling:

Each therapy session will be based on the word of God and through the love of Jesus Christ as Lord and Savior. My approach to counseling is from an eclectic perspective, considering several theories as I meet and prescribe treatment plans for each client. Some clients desire only a few counseling sessions to achieve their goals, while others may desire months or even years of counseling. You may choose to discontinue the counseling relationship at any point.

Counseling Sessions and Counseling Relationship:

Sessions are usually held weekly for about 50 or 80 minutes. As your counselor, I will do everything possible to respect your scheduled appointment times. In the case of an emergency on my part, I will contact you as soon as possible to reschedule your appointment. I ask that you please arrive on time for your counseling session and call a day or more in advance to cancel sessions you will not be able to attend. If you are in a crisis such as sickness, work, weather, etc, please call as soon as possible to avoid payment penalties. Please see the attached cancellation policy on the Fee Schedule sheet.

Although our sessions may be very intimate emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Due to ethical guidelines, I ask that you do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. My services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

Records and Confidentiality:

All of our communication becomes part of the clinical record, which is accessible to you per request, within one week from request. Kelli A. Ashlock at (325) 513-7137 will be responsible for relinquishing records, in the case of death or I am incapacitated in some way. I will keep confident anything you say to me except where I am required by ethical or legal standards to reveal information obtained during therapy to other persons or agencies – even if you do not give me permission. Those situations are outlined in the document, “Notice of Privacy Practices.” If you have any questions about those situations please review the document I have given you or request another.

By signing below you are indicating that you have read and understood this statement, and/or that any questions you had about this statement have been answered to your satisfaction.

Counselor's Signature

Client's Signature

Date

Date

File Complaints to:
Texas State Board of Examiners of
Professional Counselors
1100 West 49th Street
Austin, TX 78756-3183
512-834-6658

Parental Consent for Minors to Receive
Treatment
(Please sign and date)



FEE SCHEDULE 2010

We believe fees for counseling services are considered reasonable and customary for Mental Health Services in the San Antonio Area. Checks or Cash Only—Please make checks payable to Counseling Center for Living Well or Christina L. Russell Account Summaries are available by request only and issued once a month.

Table with 2 columns: Type of Session, Fees. Includes Initial Consult—non CPT coded, no Diagnosis, not covered by insurance \$65. Provided to guide you to your best choice for care. Paperwork and a brief presentation of problem.

Fees for Private Pay Clients are reduced by \$15 after the fourth full pay session as listed below, excluding Premarital, Group Psychotherapy and sessions with Students or Interns under the supervision of Ms. Russell. If you are returning to counseling after 3 months of no scheduled appointments, the current pay rate will apply.

Table with 3 columns: CPT CODE, Type of Session, Fees. Lists various session types and their corresponding fees, such as Initial Evaluation and Assessment (80 minutes) at \$135.00.

Table with 2 columns: Type of Sessions, Fees. Includes PREMARITAL—not covered by insurance, minimum 6 sessions recommended, 10 session standard at \$95.00.

Table with 2 columns: Type of Sessions (When Available), Fees. Includes Practicum Student or LPC-Intern—under supervision of Ms. Russell not covered by insurance, and lists fees for Initial Evaluation and Assessment for both (\$50.00), Practicum Student (50 minutes) (\$10.00), and LPC-Intern (50 minutes) (\$40.00).

Table with 2 columns: COURT APPEARANCE—Court ordered only, Fees. Includes Not covered by insurance—Counselors will not voluntarily appear in court or release records to attorneys, unless subpoenaed by a judge. We believe involvement in court or legal matters damages the therapeutic alliance. Per hour, including travel time. \$125.00. A retainer of \$500 must be paid in advance.

CANCELLATION: Please call or email 24 hours in advance of your appointment to reschedule. If 24 hour advanced notice is not given, for non-emergencies (illness, work, family crisis, etc.) you will be charged the regular fee for services. Missed appointments cannot be billed to insurance, you will be held responsible for this payment.

THERE IS A \$30 FEE FOR EACH RETURNED CHECK

LATE PAYMENT: After the initial consult, you will be billed a one time \$5 late payment fee for nonpayment at the time of session.

Client's Signature Date

Therapist's Signature Date



INSURANCE CONSENT FORM

Counseling sessions after the initial consult *may be* covered by insurance, *considering out of network benefits and if deemed medically necessary by the insurance company*. Please note that your insurance company will require submission of an appropriate *mental health diagnosis* and may require *additional private information* to process claims. Such information and diagnosis may make it difficult for you obtain individual insurance coverage (ex: if you are self-employed) and life insurance, in the future. Additionally, some employers may have access to your private insurance information.

If you would like a Superbill so that you can submit claims to your insurance company for Out of Network Mental Health benefits, please authorize below.

Please indicate how you would like to receive this monthly statement: email mailed to home address

IMPORTANT NOTICE

If a diagnosis is rendered, it will become part of your permanent medical records. Please be aware that it is the prerogative of the insurance companies to pay for a claim or not.

I hereby authorize Christina L. Russell, MA, LPC, NCC to release information to my insurance carrier to process this claim:

Signed: _____
Policyholder

Signed: _____ Date: _____
Claimant, if other than Policyholder

See the Notice of Privacy Practices for detailed information regarding the disclosure of PHI (Protected Health Information). Briefly, your PHI, name, address, social security number, etc., may be used by Counseling Center for Living Well, PLLC—Counseling Center for purposes of treatment, payment and healthcare operations during our normal business operations.

Termination of Counseling Relationship

It is preferred that we discuss termination of counseling in the counseling session. This is helpful in transitioning either to another counselor or when counseling is no longer needed. Termination may either be suggested by the counselor or client and in most cases we come to this decision together. After three months of no scheduled sessions, your account is considered closed and the counseling relationship terminated, whether we've discussed a formal termination in session or not. You are always welcome to reopen the counseling relationship. The current fees at the time of your return to counseling will apply.

Please sign indicating you are aware of this policy _____

Date _____

CONFIDENTIAL CLIENT INFORMATION

Answering all of the following information helps us maintain proper confidential records and provide you with quality service. **The information in bold is especially important.** However, any questions on the entire questionnaire you do not want to answer may be left blank. Thank you.

Today's Date _____

Client's (Child/Teen) Name _____ M ___ F ___ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Caregiver's Telephone: Home _____ Work _____ Cell Phone _____

Primary Caregiver _____ Caregiver's Email: _____
(Email is used for appointments and administration, but not for counseling. Counselors do not communicate by email with minors, only caregivers. By giving us your email address you are giving us permission to contact you related to appointments and administration. We cannot guarantee the privacy of email.)

Please indicate where we may leave a voice message and send correspondence by mail: _____

Length of time child has been at above address _____ Child's place of birth _____

Child's school _____ Length of time child has attended this school _____ Current Grade _____

HEALTH INFORMATION

Rate child's health (check): Very Good ___ Good ___ Avg. ___ Declining ___

Child's approximate weight ___ lbs. Weight changes recently: Lost _____ Gained _____

List all important present or past illnesses or injuries or handicaps: _____

Has your child currently or within the last 6 months taken medication, excluding occasional over the counter? ___

Please list _____

PSYCHOSOCIAL INFORMATION

Has your child ever had a severe emotional upset? ___

Explain _____

Has your child recently suffered a loss or major change (social, family, pet, move, etc. .)? ___

If yes, please explain _____

Has your child ever been a victim of a crime? ___

If yes, have you filed with Texas Crime Victims Compensation? ___

RELIGIOUS BACKGROUND

Caregiver's denominational preference: _____ Church member: Yes No
Church attendance: (circle) occasionally, mainly holidays monthly weekly more than once a week

Church you and/or your child currently attends: _____

Is your (caregiver's) spiritual life meaningful to you? ____ As best as you know, is your child's spiritual life meaningful to him/her? (if completed by child/teen please indicate) ____

Explain recent changes in your and/or your child's spiritual life, if any _____

PSYCHOLOGICAL HISTORY

Have you or your child ever had any psychotherapy or counseling before? ____ If yes, list counselor or therapist and approx. dates:

What was the purpose and outcome?

Are you or your child currently seeing another therapist, counselor, psychiatrist, etc. ____

If yes for your child, please list name and contact information

A release will need to be signed to contact your therapist/psychiatrist before we continue in counseling services.

FAMILY INFORMATION

Please complete regardless of living arrangements or death for biological or adoptive parents.

Father's Name _____ Age ____ Education _____

Mother's Name _____ Age ____ Education _____

Father's Occupation _____ Length of time with current employer _____

Mother's Occupation _____ Length of time with current employer _____

Hours at work weekly: Mother ____ Father _____ Current Caregiver, if neither Mother or Father

Are the mutual parents married? ____ Separated? ____ Divorced? _____

List all children in the family

| Name | Age | School Grade | Lives with child |
|-------------|------------|---------------------|-------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

(if necessary, please list additional children on a separate sheet).

Who is responsible for payment of services? _____ Phone Number

Address (if different than previously listed) _____ City _____ State

Zip _____

In case of emergency, whom shall we contact (other than parents)?

All the above information is true to the best of my knowledge.

Signature of Parent or Guardian

Authorization for Release of Information

ONLY COMPLETE , THIS PAGE, IF YOU WILL BE SIMULTANEOUSLY IN COUNSELING WITH ANOTHER PROFESSIONAL, UNDER MEDICAL TREATMENT FOR A MENTAL HEALTH DISORDER, OR IF DETERMINED THROUGH OUR SESSIONS NECESSARY FOR COMPLETE TREATMENT.

Full Name of client _____

Address _____

Date of Birth _____

Authorization Must be completed in full

I hereby give consent to _____ . To release to or receive from:

Name

Address

City, State and Zip Code

This information to be released is limited to _____ .

Type(s) of information must be specified(e.g. psychological, emotional, No limits etc.)

For the following purpose and that purpose only. Any other use or re-use of the information is forbidden.

Reason information is wanted must be specified (e.g. further evaluation, additional treatment, etc.)

Sign Here:

I understand that I can revoke this authorization at any time, in writing, except for the action previously taken on this authorization. Unless revoked earlier, this authorization will expire on the following, or if not specified, ninety (90) days from the date signed.

Date, event, or condition upon which consent will expire

I have read, or had read to me, the above, and understand the contents.

On this, the _____ day of _____, 2010.

Sign Here:

Witness

Client

Title

Parent/Legal Guardian

CLIENT SELF-EVALUATION

For Adolescents Only

Please rate each of the following concerns as they apply to you at the present time on a scale of 1 to 5 (1 = **not a problem, no concern**; 5 = **a very strong or severe concern or problem**)

| | | | | | |
|--|---|---|---|---|---|
| Feelings of sadness, crying, being ‘down’ | 1 | 2 | 3 | 4 | 5 |
| My mind feels like it’s racing | 1 | 2 | 3 | 4 | 5 |
| Unwanted thoughts in my mind | 1 | 2 | 3 | 4 | 5 |
| Sometimes I can’t control what I do | 1 | 2 | 3 | 4 | 5 |
| Sleep problems | 1 | 2 | 3 | 4 | 5 |
| Feeling worthless | 1 | 2 | 3 | 4 | 5 |
| Problems with anger/temper | 1 | 2 | 3 | 4 | 5 |
| Feeling like things aren’t real | 1 | 2 | 3 | 4 | 5 |
| Problems with my eating | 1 | 2 | 3 | 4 | 5 |
| There are things too painful to talk about | 1 | 2 | 3 | 4 | 5 |
| Concerns about my sexual identity | 1 | 2 | 3 | 4 | 5 |
| Use of alcohol and/or drugs | 1 | 2 | 3 | 4 | 5 |
| Doing things over and over | 1 | 2 | 3 | 4 | 5 |
| Seeing or hearing things that others don’t | 1 | 2 | 3 | 4 | 5 |
| Feeling anxious/nervous | 1 | 2 | 3 | 4 | 5 |
| Being close to people | 1 | 2 | 3 | 4 | 5 |
| Spiritual concerns | 1 | 2 | 3 | 4 | 5 |
| Pain and/or health concerns | 1 | 2 | 3 | 4 | 5 |

Please indicate below the length of time (beginning of occurrence and frequency) you have experienced concerns rated above at a 4 or 5:

Are there current or past relationships that are a particular concern for you? Please describe briefly; _____

What are the most significant stresses that you are currently dealing with? _____

If things were better than your current situation, what would it look like? _____

What are your strengths? _____
