Hope Psychological Services, pllc

5501 Louetta Rd, Suites B&C, Spring, TX 77379 • 281-210-6945

CONSENT FOR EVALUATION/TREATMENT

Child/Client's Name: ____ Date of Birth: ____________________

I, ________________________________, hereby give full consent for my child to receive services until I notify Dr. Paige Schultz, PhD, LPC-S, NCC & Associates, if services are no longer appropriate, or if services will no longer be provided. If applicable: I certify that I have the legal authority to authorize and consent to treatment or evaluation as parent, managing conservator, or guardian of this child.

I authorize Dr. Paige Schultz, PhD, LPC-S, NCC & Associates to carry out the psychological assessments and treatment that are advisable during the course of my child's psychotherapy. I understand that while the assessment and treatment is designed to be helpful and beneficial, it may at times be difficult and uncomfortable due to discussion of unpleasant life events or uncomfortable feelings like sadness, anger, guilt, or frustration. However, benefits from therapy can include better relationships, solutions to specific problems, and significant reductions in feelings of distress. There is an expectation that my child will benefit from the assessment or treatment, but there is no guarantee this will occur. Therapy also requires an active effort on my/my child's part and may include activities or assignment to complete at home. Psychotherapeutic treatment also includes the possibility that symptoms may worsen before improving, and that there is no guarantee of a cure. If I have questions about treatment procedures, I will discuss them with my child's therapist. If doubts persist, I will ask my child's therapist about other options for treatment that may include referrals to other therapists.

SESSIONS

Psychotherapy sessions are 45 to 50 minutes in length. An initial evaluation is conducted to determine the appropriate services and treatment goals, and it can take more than one session to complete. Formal treatment is not initiated until the therapist and client agree to do so, and it will be conducted weekly at an agreed upon time. If a session needs to be cancelled, 24 hours notice is required. If a client misses 2 or more consecutive appointments, Dr. Paige Schultz, PhD, LPC-S, NCC & Associates reserves the right to remove the client from her schedule at the previously agreed upon time and discharge the client. If the client is interested in continuing services, future appointments will be scheduled at an available time according to the therapist's schedule and may not be at the same time as previous appointments.

CONTACTING YOUR THERAPIST

Your therapist is typically available by telephone during business hours unless with a client. When unavailable, the telephone is answered by voice mail that is monitored frequently. Dr. Paige Schultz, PhD, LPC-S, NCC & Associates will attempt to return your call within 24 hours, or on the next business day with exceptions of weekends and holidays. Calls identified as emergencies will be returned as soon as possible. If you are difficult to reach, please leave times you will be available. If you are unable to reach your therapist and are unable to wait for a return call, contact your family physician, the crisis hotline (713-468-5463), call 911, or the nearest hospital emergency room.

CONFIDENTIALITY

The law protects the privacy of all communications between a therapist and the client. Information provided in therapy is confidential and generally will not be released to others without the client's written consent. There are professional ethical obligations, or state and/or federal law require the clinician to disclose confidential information without the client's consent in certain circumstances. If disclosure is necessary, Dr. Paige Schultz, PhD, LPC-S, NCC & Associates will make every reasonable effort to inform the client of the disclosure. Typically, information about your treatment is only released to others if you sign a written Authorization form. This signed agreement provides consent for the following:

- If any information concerning the abuse of a child, elder or disabled person is disclosed, the therapist is mandated by law to make a report to the proper authorities.
- If the therapist determines there is a probability the client will inflict harm on either himself/herself or others, the therapist is required to warn the intended victim and report this information to medical or law enforcement personnel. By signing this form, you specifically give irrevocable permission to warn those parties the therapist feels may be harmed. If the client reveals an intent to harm himself/herself, the therapist has permission, also irrevocable, to attempt to prevent the client from accomplishing that intent.
- If a client is involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected and cannot be provided without your (or your legal representative's) written authorization or a court order.

- If a client has been referred by a managed care or insurance company or a client plans to have the therapist file for reimbursement with a managed care or insurance company, the managed care or insurance company may require information about the diagnosis and treatment records. When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts.
- If a government agency is requesting the information for health oversight activities, the therapist may be required to provide it to them.
- In the event of a client's death, the personal representative of the deceased client has a right to access his/her records.
- If the client files a lawsuit against the therapist or if a court order, legal proceeding, statute, or regulation requires disclosure of records, the therapist may be required to release of the client's therapy records.
- Your therapist may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of clients. The other professionals are also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations unless your therapist feels that it is important to your work together.

More information regarding confidentiality is provided in the Notice of Privacy Practices.

RECORDS

The therapist by law maintains a record of the treatment given to the client and contains the information that will allow the therapist to chart the course of therapy (i.e. reason for seeking therapy, your treatment history, records from other past providers, progress towards goals, billing records, and insurance information). The therapist will use it only for that purpose, and no one will see what is contained in the file unless an authorization is signed or it meets previously stated criteria. Except in circumstances that involve danger to the client and others, the client may get a copy of the file by submitting a signed release of information request. A synopsis of the course of treatment and outcome may be provided in lieu of the actual record if deemed appropriate by the therapist. A copy fee per page will be charged. Because these are professional records and can be misinterpreted or be upsetting to untrained readers, it is recommended you review them in the presence of your therapist. In the event of the client's death, these requirements will be binding on any heirs, successors or executor(s).

If the therapy sessions contain more than one client, the therapist will attempt to maintain separate records on each client. However, only that individual is entitled to his/her own record. The therapist may summarize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If the client chooses to utilize insurance plans with a managed care or insurance company, the therapist may have to share information about the client's treatment and diagnosis. The therapist will do so as required to obtain all the treatment that is appropriate. The managed care or insurance company is not bound by the same ethical and legal requirements on maintaining the confidentiality the client's treatment records may require. Once these records are in the possession of the managed care or insurance company, Dr. Paige Schultz, PhD, LPC-S, NCC & Associates cannot guarantee their continued confidentiality.

MINORS & PARENTS

Because privacy is often crucial to success, your therapist will typically provide parents only with general information regarding the child's treatment. Before giving parents any additional information, the therapist will discuss the matter with the child.

PAYMENT

Payment is due at the time of service unless otherwise arranged prior to the appointment or if an insurance plan requires other arrangements. Payment schedules for other professional services will be agreed to when they are provided. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Dr. Paige Schultz, PhD, LPC-S, NCC & Associates have the option of using legal means to secure payment. Use of a collection agency or small claims court will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers. If Dr. Paige Schultz, PhD, LPC-S, NCC & Associates are an in-network provider for your insurance carrier, they will bill in accordance with their policy less any applicable co-payments. If the are an out-of-network provider for your insurance carrier, Dr. Paige Schultz, PhD, LPC-S, NCC & Associates will not fill out forms nor will they submit your requests to your insurance company unless agreed upon at the initiation of services. They can provide an "Insurance Superbill" that you can submit for out-of-network reimbursement. Dr. Paige Schultz, PhD, LPC-S, NCC & Associates will provide you with whatever assistance they can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of the fees.

Your contract with your health insurance company might require that Dr. Paige Schultz, PhD, LPC-S, NCC & Associates provide information such as a clinical diagnosis, treatment plans or summaries, or copies of the entire record. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, this therapist has no

control over what they do with it once it is in their hands. By signing this agreement, you agree that Dr. Paige Schultz, PhD, LPC-S, NCC & Associates can provide requested information to your carrier.

TERMINATION OF TREATMENT

The length of time required for therapy will be determined by your child's personal situation, and your therapist will do her best to fulfill your child's therapeutic needs and to provide your child with the best professional care. You and your child agree to participate in the process as needed to the best of his/her ability. It is intended that when the child's needs are met, to the extent that they can be, the therapeutic relationship will be terminated. There is no guarantee of a cure, and a client may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, notification in writing, informing the clinician verbally, failing to maintain the appointment schedule without proper notification, or failure to follow treatment recommendations. If a client misses 3 or more consecutive appointments, the therapist reserves the right to remove the client from her schedule at the previously agreed upon time and discharge the client. If the client is interested in continuing services, future appointments will be scheduled at an available time according to the therapist's schedule and may not be at the same time as previous appointments.

FOR PATIENTS REQUESTING MEDICAID/INSURANCE BILLING

In the event Dr. Paige Schultz, PhD, LPC-S, NCC & Associates file claims for insurance reimbursement, my signature below authorizes payment of benefits to be issued directly to Dr. Paige Schultz, PhD, LPC-S, NCC & Associates. If my insurance company mistakenly remits payment to me, I agree to send that check along with any paperwork to Dr. Paige Schultz, PhD, LPC-S, NCC & Associates. I authorize the release of any medical or treatment information needed to determine benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information as required by the managed care/ insurance company. This authorization shall remain valid until written notice is given by the revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

PLEASE INITIAL____________

DIVORCED PARENTS SEEKING TREATMENT/DOCUMENTATION OF RIGHT TO SEEK TREATMENT FOR CHILD

By signing below, I certify that I have the legal right to seek mental health treatment for the child identified above. I understand that before treatment can begin I must provide a copy of the divorce decree with the section identifying my right to seek mental health treatment clearly highlighted. I also understand that it is the policy of Dr. Paige Schultz, PhD, LPC-S, NCC & Associates to contact the parent that is not seeking treatment to ensure s/he is informed his or her child will be participating in an evaluation or ongoing treatment. This is as a courtesy to both parents and to make certain the child is not receiving duplicate services. In addition, treatment is usually most successful with the cooperation of both parents. I have had the opportunity to address any concerns about this policy.

PLEASE INITIAL____________

Your signature on this consent form verifies that you have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that your questions were answered to your satisfaction by the therapist, and you voluntarily give your consent for treatment. You also understand that you have the right to withdraw your consent for treatment at any time.

______________________________________ ______________________

Client (or Parent/Guardian) Signature Date

____

Printed Name of Client

____

Relationship to Client

______________________________________ ______________________

Signature of Witness Date

PERSONAL HISTORY QUESTIONNAIRE

Please take a few moments to complete this questionnaire. Feel free to write on the back of the page.

Client Name: ______________________ Date of Birth: ______________ Age: __________

Current Grade: __________ Social Security Number: __________________ Ethnicity: ____________

Address: ____

City: ________________________________ State: __________ Zip: ______________

Caregiver's name *(if not in parent's custody)* ____________________________________

Mother's name: ____________________________________ Date of Birth: ______________

Address *(if different than above)*: ____

Father's name: ____________________________________ Date of Birth: ______________

Address *(if different than above)*: ____

Mother's Cell Phone: ____________________ May I leave a message? Yes No
May I send you a text message? Yes No

Father's Cell Phone: ____________________ May I leave a message? Yes No
May I send you a text message? Yes No

Child's Cell Phone: ____________________ May I leave a message? Yes No
May I send you a text message? Yes No

Home Phone: ____________________ May I leave a message? Yes No

Work Phone: ____________________ May I contact you/leave a message at work? Yes No

Occasionally it is easier to communicate about appointments through email than phone. If you would like the option of communicating about issues such as appointments, scheduling, payments, etc, please list email addresses below. It is important to note, however, that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for advice, treatment, or any other form of intervention with your provider. By listing email addresses below, you are acknowledging your understanding of these statements.

Mother's Email address: ____

Father's Email address: ____

Child's Email address: ____

Would you like an email reminder of your appointments? (Note: You can unsubscribe from the email at any time) Yes No

REASON FOR SEEKING PSYCHOTHERAPY

What brought you here for treatment? How long has this problem persisted?____________________

____

How did you find out about me? ____

Under what conditions to the problems usually get worse? Get better? ____________________

____

What do you hope to gain out of therapy? What changes do you hope to make? ______________

____

FAMILY HISTORY

Mother's Highest Education Completed: ______________________________ Occupation: ________________________________

Place of Employment & Status: ____

Relationship Status: ____

Father's Highest Education Completed: ______________________________ Occupation: ________________________________

Place of Employment & Status: ____

Relationship Status: ____

Please list family members who live in the home and their ages. Please include stepparents, stepsiblings, grandparents, etc.

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Has there been a divorce in the family? If so, when? What are the custody arrangements? ________________________________

____

MEDICAL HISTORY

From Whom or Where does your child receive medical care? *(Please include psychiatrists)*

Physician/Clinic Name: ________________________________ Phone: ________________________

Physician/Clinic Name: ________________________________ Phone: ________________________

Is your child taking any medication? If so, please list name and dosage

Name: ________________________ Dosage: ______________ Reason: ________________________

Name: ________________________ Dosage: ______________ Reason: ________________________

Name: ________________________ Dosage: ______________ Reason: ________________________

Does your child have allergies? ❑ Yes ❑ No If yes, please explain any precautions needed ________________________

____

Past Major Illness/Injuries/Operations? ____

DEVELOPMENTAL HISTORY

❑ No Birth/Developmental History Known

Child's birth weight: ____________ Mother's age at birth: ___________ Did mother receive prenatal care? ❑ Yes ❑ No

Pregnancy course? ❑ Normal ❑ physical injury ❑ hypertension ❑ diabetes ❑ smoking ❑ alcohol ❑ drugs ❑ other: ____________

Delivery/Labor? ❑ Normal ❑ induced labor ❑ C-section ❑ breech ❑ prolonged labor > 12 hrs ❑ other: ________________

Condition at birth? ❑ Normal ❑ lack of oxygen ❑ breathing problems ❑ birth injuries/defects ❑ jaundice ❑ ICU ❑other: ________

Milestones (Please circle correct time range)

Sat up without support	3-6 months	7-12 months	over 12 months
Crawled	6-12 months	13-18 months	over 18 months
Walked without assistance	under 1 year	12-24 months	2-3 years
Spoke 1st word	9-13 months	14-18 months	19-24 months
Said sentences	14-18 months	19-24 months	25-36 months
Potty Trained	under 18 months	18-30 months	over 30 months

Has your child been diagnosed with a developmental disability or delay? ❑ Yes ❑ No If yes, please explain ____________

____

MENTAL HEALTH HISTORY

Has your child been in psychotherapy before? If so, please list the therapist's name, contact information, & description of what issues that were addressed in therapy? ____________________

____

____

Did you find therapy helpful? ❑ Yes ❑ No If no, please explain ____________________

____

____

Has the child or any family member struggled with any of the following problems?

	Child	Mother	Father	Sibling	Other
Depression, Sadness					
Anxiety/Excessive Worries					
Panic Attacks					
Obsessions &/or Compulsions					
Suicidal Thoughts					
Attempted Suicide					
Learning Disabilities					
Attention Deficit/Hyperactivity					
Anger Problems					
Assertiveness Problems					
Oppositional/Defiant Behavior					
Schizophrenia or Psychosis					
Nervous Breakdown					
Heavy Alcohol Use					
Drug Use/Abuse					
Smoking/Tobacco Use					
Eating Disorder					
Physical or Sexual Abuse					
Other:					

ANYTHING ELSE?

Is there anything else you would like to make sure I know? ____________________

____

____

____

____

____

NICHQ Vanderbilt Assessment Scale – PARENT Informant*

Today's Date: ______________ Child's Name: __________________________ Date of Birth: ______________

Parent's Name: ______________________________ Parent's Phone Number: ______________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2.	Has difficulty keeping attention to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by noises or other stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when remaining seated is expected	0	1	2	3
12.	Runs about or climbs too much when remaining seated is expected	0	1	2	3
13.	Has difficulty playing or beginning quiet play activities	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22.	Deliberately annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or resentful	0	1	2	3
26.	Is spiteful and wants to get even	0	1	2	3
27.	Bullies, threatens, or intimidates others	0	1	2	3
28.	Starts physical fights	0	1	2	3
29.	Lies to get out of trouble or to avoid obligations (i.e. "cons" others)	0	1	2	3
30.	Is truant from school (skips school) without permission	0	1	2	3
31.	Is physically cruel to people	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
33.	Deliberately destroys others' property	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically cruel to animals	0	1	2	3
36.	Has deliberately set fires to cause damage	0	1	2	3

* *Copyright 2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality. Revised 1102*

NICHQ Vanderbilt Assessment Scale – PARENT Informant*

Today's Date: ______________ Child's Name: ________________________ Date of Birth: __________________

Parent's Name: ________________________________ Parent's Phone Number: ______________________

	Symptoms	Never	Occasionally	Often	Very Often
37.	Has broken into someone else's home, business, or car	0	1	2	3
38	Has stayed out at night without permission	0	1	2	3
39.	Has run away from home overnight	0	1	2	3
40.	Has forced someone into sexual activity	0	1	2	3
41.	Is fearful, anxious, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels worthless or inferior	0	1	2	3
44.	Blames self for problems, feels guilty	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46.	Is sad, unhappy, or depressed	0	1	2	3
47.	Is self-conscious or easily embarrassed	0	1	2	3

	Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48.	Overall school performance	1	2	3	4	5
49.	Reading	1	2	3	4	5
50.	Writing	1	2	3	4	5
51.	Mathematics	1	2	3	4	5
52.	Relationship with parents	1	2	3	4	5
53.	Relationship with siblings	1	2	3	4	5
54.	Relationship with peers	1	2	3	4	5
55	Participation in organized activities (e.g. teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1-9: __________

Total number of questions scored 2 or 3 in questions 10-18: __________

Total Symptom Score for questions 1-18: __________

Total number of questions scored 2 or 3 in questions 19-26: __________

Total number of questions scored 2 or 3 in questions 27-40: __________

Total number of questions scored 2 or 3 in questions 41-47: __________

Total number of questions scored 4 or 5 in questions 48-55: __________

Average Performance Score: __________

NICHQVanderbiltParent.20050602

* *Copyright 2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality. Revised 1102*

CONSENT FOR COMMUNICATION WITH PRIMARY CARE PHYSICIAN

In an effort to coordinate the care of my clients with their providers in the community, as well as to fulfill insurance obligations, I am requesting your permission to inform your/your child's primary care physician about your/your child's participation in an assessment and/or treatment. At times, speaking with a primary care physician is helpful, especially concerning issues of medication, treatment follow-up, and psychological issues affecting your/your child's well-being. Moreover, as your/your child's primary care physician carries responsibility for your/your child's medical care, it is important the physician have access to information related to your/your child's health and treatment.

______________________________	______________________________
Client's Name	Date of Birth

PHYSICIAN INFORMATION

______________________________	______________________________
Name of Physician	Physician's Phone Number

____

Physician's Address City, State, and Zip

CONSENT

❑ I, ______________________________, hereby give permission for the mutual exchange of pertinent information with my/my child's primary care physician, including academic, social, medical, psychological, and/or psychiatric information.

❑ I,______________________________, hereby decline to give permission for the mutual exchange of pertinent information with my/my child's primary care physician.

I may revoke this authorization in writing at any time. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. This authorization was explained to me and I signed it of my own free will.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Printed Name	Relationship to Client
______________________________	______________________________
Witness	Date

Hope Psychological Services, pllc

5501 Louetta Rd, Suites B&C, Spring, TX 77379 • 281-210-6945

Notice of Privacy Practices

In accordance with the Health Insurance Portability & Accountability act (HIPAA), this notice describes how health information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Uses and Disclosures for Treatment, Payment, & Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

Clarification of terms:

- *PHI* refers to information in your health record that could identify you.
- *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 another therapist.
- *Payment* is when I obtain reimbursement for your healthcare. An example of payment is when I 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 my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *Disclosure* applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

Uses & 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 treatment, and these notes are given a greater degree of protection than PHI. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require client authorization.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. After that time, I will not use or disclose your information. However, I cannot rescind information previously disclosed with your permission. You may not revoke an authorization if it was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. If you no longer desire that I provide the insurance company/managed care company with any information, you will be responsible for payment of all fees.

Other uses and disclosures not described in the Privacy Notices will be made only with authorization from the individual.

Uses & Disclosures Not Requiring Authorization

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

- **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 to any local or state law enforcement agency. 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.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding & a request is made for information about your diagnosis, treatment, and/or therapeutic records, such information is privileged under state law, I will not release information without written authorization from you, your personal or legally appointed representative, or a court order. If I receive a subpoena, discovery request, or other lawful process for information, PHI may have to be released. This would occur only after attempts to contact you about the request. If a complaint is filed against me with the Texas State Board of Examiners of Professional Counselors, they have the authority to subpoena confidential mental health information from me relevant to that complaint.

- **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.

- **Specific Government Functions:** PHI of military personnel and veterans may be disclosed to government benefit programs relating eligibility and enrollment. PHI may also be disclosed to Workers Compensation and Disability programs, to correctional facilities if you are an inmate, and for nation security reasons.

Client Rights & Therapist's Duties

<u>Client's Rights:</u>

- *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 seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy of your records. Access to your PHI may be limited or denied under certain circumstances, but in most 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 in writing an amendment of PHI for as long as the PHI is maintained in the record. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, an explanation stating why will be provided to you. If your request is approved, I will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
- *Right to Restrict Information to Insurance Companies* – You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service.
- *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. On your request, I will discuss with you the details of the accounting process.
- *Right to be Notified* – Affected patients have the right to be notified following a breach of unsecured protected health information
- *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.

<u>Therapist's Duties:</u>

- 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, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, a new notice will be posted in the office, or you may obtain any new notice by telephone or written request.

Questions & Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact this office by telephone or letter.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

Effective Date, Restrictions, & Changes to Privacy Policy

This notice will go into effect on May 1, 2012.

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 by posting the change in the office or on my website. You may also obtain any new notice by contacting this office by telephone or written request.

You may contact me at:
Dr. Paige Schultz, PhD, LPC-S, NCC
5501 Louetta Rd, Ste C
Spring, TX 77379
281-210-6945

Hope Psychological Services, pllc

5501 Louetta Rd, Suites B&C, Spring, TX 77379 · 281-210-6945

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

In the Notice of Privacy Practices, you are provided with information about how your/your child's personal and health information can be used or disclosed. As described in the Notice of Privacy Practices, we request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review the Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you acknowledge that a copy of the Notice of Privacy Practices has been provided to you.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in compliance with this Consent.

____
Client's Name (Printed)

____	______________________
Client (Parent/Guardian) Signature	Date
____	______________________
Printed Name of Parent or Legal Representative	Relationship to Client
____	______________________
Witness Signature	Date