BOND BUCHANAN, MA, LMFT ASSOCIATE

AGREEMENT FOR SERVICE/INFORMED CONSENT

Fee Arrangements

Payment is due at the beginning of each session by cash (exact change) or check (made payable to Bond Buchanan). The usual and customary fee for service is $100 for a 45 minute session. Private pay only. No insurance accepted.

Qualifications of Therapist

An LMFT Associate has already completed an internship/practicum, received a Master's degree, and passed the national marital & family therapy exam. An LMFT Associate must continue to work under the supervision of a board approved supervisor for an additional minimum of two years/3,000 hours before they can work without supervision. The supervisor is Susan Martinez, MA, LMFT-S.

Cancellations

If you must cancel or reschedule an appointment, please call your therapist and leave a voicemail indicating so at least 24 hours in advance of your scheduled appointment or a $25 fee will be charged.

Confidentiality

Therapy sessions are confidential. There are some legal and ethical exceptions to this confidentiality including; danger to self and others, and suspicion of child, elder, and dependent adult abuse. No secrets policy for couples and families: Information shared with me by one participant will be open for discussion with the other participants, when clinically appropriate.

Risks and Benefits of Therapy

Psychotherapy is a process in which we will discuss a myriad of issues for the purpose of creating positive change so that you can experience your life more fully. Psychotherapy is a joint effort. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thought and behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on your part, as well as family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some emotional discomfort. There may be times in which your therapist will challenge the perceptions and assumptions of you and other family members, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Your therapist will not make decisions about your life and your relationships for you. Your therapist will help explore and discuss issues and options, but you will make the decisions.

Dual Relationships

Your therapist will avoid a therapeutic relationship with a personal friend, educational or business associate and will avoid the development of a personal, educational or business relationship with a therapy client.

Termination of Therapy

If at any point during therapy, your therapist assesses that he/she is not effective in helping you reach the therapeutic goals, he/she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she/he would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time.

Client Litigation

Your therapist will not testify in civil or family court. There are other mental health professionals who offer forensic services such as psychological evaluations and custody evaluations. Your therapist can offer referrals if you counseling, testimony, or a report for legal purposes. It is agreed that should there be family court or civil legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

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Complaints

Complaints may be made to the Texas State board of Examiners of Marriage and Family Therapists at Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540.

Acknowledgement

By signing below, you consent to treatment and acknowledge that you have reviewed and fully understand the terms and conditions of this agreement. You agree to abide by the terms and conditions of this Agreement and consent to participation in psychotherapy. Moreover, you agree to hold the therapist and the supervisor, Susan Martinez, MA, LMFT-S free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. By signing below, you also authorize communication with the referring party for the purpose of assessment and treatment planning.

Adult Client Name	Date of Birth	Signature	Date

Adult Client Name	Date of Birth	Signature	Date

Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date

I understand that I am financially responsible for all charges.

Name of Financially Responsible Person (printed)	Signature	Date Signed

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HIPAA NOTICE OF PRIVACY PRACTICES

The effective date of this Notice is July 15, 2015.

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or providing one to you at your next appointment. PHI is subject to electronic disclosure.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities, or collections.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect, Suicidal. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, danger to self (suicide).

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent),court order, administrative order or similar, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in

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connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
Public Health.If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
Research.PHI may only be disclosed after a special approval process or with your authorization.
With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.
YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our **Privacy Officer, Bond Buchanan, at 903-746-4681.**
Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service for out of pocket. In that case, we are required to honor your request for a restriction.
Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to a Copy of this Notice. You have the right to a copy of this notice.
COMPLAINTS If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Privacy Officer, Bond Buchanan, MA, LMFT Associate at 609 Cheek-Sparger Rd Suite 104 Colleyville, TX 76034 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the notice of privacy practices of Bond Buchanan, MA, LMFT Associate. My privacy practice notice provides information about how I may use and disclose health information that I maintain about you.

Adult Client Name	Date of Birth	Signature	Date
Adult Client Name	Date of Birth	Signature	Date

Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date
Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date

_____ _____

Therapist Signature Date

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Client Preferences Regarding Communication of Patient Health Information (PHI)

Please be aware that computers and unencrypted email and texts can be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. If you communicate confidential or private information via email or text, it is assumed that you have made an informed decision and will be viewed as your agreement to take the risk that such communication may be intercepted, and your desire to communicate will be honored. Clinical matters are typically discussed in person, in session. But it may be necessary to communicate with you between sessions about billing or appointment scheduling, rescheduling, reminders, etc.

I am informed of the risks of communicating via email and text and I choose to receive communication via the following methods: (please initial and specify below any and all acceptable communication methods)

__ home phone: _____

__ Mailed letter: _____

__ Work phone: _____

__ Cell phone voicemail:_____

__ Cell phone text:_____

__ Email:_____

This authorization is valid until the earlier of the occurrence of the death of the individual or permission is withdrawn or the following specific date (optional) _____.

Client Name (please print)

Signature of Client, Parent, or legal guardian **Date**

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CLINICAL RECORD FORM

Please list the name, date of birth, age, and relationships of each therapy participant.

_____

_____

_____

Please list any other household members names, ages, relationships that are not participating in therapy.

_____

_____

When answering the following questions, please list responses for each participating family member.

Current Medical Conditions: _____

_____

Current Medications, Herbal Supplements & Vitamins (Daily Dose, Start Date, Name of Prescriber):

_____

_____

Allergies/Adverse Reactions to Treatment/Medication/Food:_____

Physician(s) Name and contact info:_____

Other current Mental Health Professionals: _____

Prior mental health treatment: _____

Reason for Seeking Counseling Today: _____

_____

_____

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