KIMBERLY BOYD
COUNSELING CENTER LLC

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Practice Policies

Welcome to Kimberly Boyd Counseling Center, LLC and thank you for choosing this practice. This document contains important information about the professional services and business policies. When you sign this document, it will represent an agreement.

Counseling Process: Counseling is a collaborative and interactive process between the client and counselor. Being an active participant in the counseling process is strongly encouraged. Each client is an individual with unique characteristics that makes that person who they are.

Each counselor is an independent counselor practicing within Kimberly Boyd Counseling Center, LLC. Each counselor has their chosen style and practice. Discuss your counselor's approach, style, process, and practice during your initial session. Unless otherwise indicated by your counselor, your sessions will be scheduled central standard time (CST).

Fees: Session fees using insurance benefits can range from $200 to $400. If you choose to utilize insurance or Medicaid benefits, you will be responsible for any deductibles, co-payments, coinsurance or any variation thereof dictated and/ or mandated by your insurance carrier. Please speak with your counselor regarding any questions. Administration at Kimberly Boyd Counseling Center, LLC will submit claims and receive payments on behalf of your counselor. Contact your counselor or administration with any questions regarding claim submission, accounts receivable, and account payables.

*Cash rates for LPCs are $120.00 per individual session and $150.00 for marriage counseling. *Cash rates for LPC Associates and Graduate Student Interns are $45.00 for individual sessions and $65.00 for marriage/family counseling. Professional services include, but are not limited to, office appointments, therapeutic phone calls, third party consultations, written and verbal correspondence, and reports. *Phone consultations lasting 10 minutes or more will result in a session fee. *Evaluations/assessments are not a covered treatment/procedure under your individual insurance plan; therefore, the entire cost will be due at the time of service. The full assessment fee is $995.00. Court costs require a nonrefundable initial payment of $500.00, then an additional $250.00 per hour for time at court. *Failure to provide 24-hour notice of appointment cancellation will result in a $110.00 fee for an initial and $90.00 for a follow up appointment. **Payment by cash, check, or credit card is due at the time of service. All checks are to be made out to Kimberly Boyd Counseling Center, LLC. Returned checks will be charged an additional $25.00.

Request for Records: Requests for Records must be submitted in writing to your counselor. Once the written request is received, your counselor will attend to your request according to their licensing guidelines. The first 20 pages will incur a charge of $25.00. Each additional page is $.50. Documents requiring a Notary will incur an additional charge of $15.00. You may submit your payment to Kimberly Boyd Counseling Center, LLC and your clinician will be notified of your payment.

Cancellations: Please provide 24-hour notice for cancellation and/or rescheduling of an appointment. You may cancel through your secure on-line portal, through your counselor directly, or contacting the office. Failure to provide 24-hour notice will result in a charge of $90.00. This fee can be charged to the credit card on file with your provider by your provider or Kimberly Boyd Counseling Center, LLC administration or paid by cash, check, or money order.

Insurance: If you request that your services are billed to your insurance carrier, please complete the Insurance Authorization and Release. You are responsible for all fees not covered or reimbursed by your insurance benefits, including but not limited to: deductibles, co-payments, co-insurance, missed appointments, late cancellations, correspondence/reports or services not approved by your plan. Any non-covered fees will be charged to the credit card on file. (See Financial Policy and Agreement) If the counselor is not a provider for your insurance plan, you may have out-of-network benefits through your insurance company. If you have such benefits, the office or your counselor can provide you with a receipt that you may submit to your insurance so you can request reimbursement.

Contacting your counselor: Although counselors are not often immediately available by telephone, we make every effort to promptly respond to messages. Please leave an evening number since calls are often returned after hours. Your counselor will provide you with their email address so you can reach them directly. Because technical difficulties do sometimes occur, please call again if you have left a voice message at the office and have not received a return call by the end of the next business day. You may also send an email to Info@KimberlyBoyd.Net to request to be contacted by your counselor.

Emergency care: If you are experiencing an emergency and need to talk to someone immediately, call 911, a telephone crisis line or go to the nearest emergency room.

Privacy rights: Professional ethics and legal standards require that conversations and records (even the fact that you are a client) be kept confidential. However, under the following circumstances, your counselor is legally and ethically obligated to breach confidentiality: (a) if you present a serious imminent danger to yourself or others (b) in cases of apparent neglect of a child, an elderly person, or a disabled person (c) when required by legal proceedings. confidentiality must be breached; the minimum amount of information will be revealed – only enough to protect you or others.

If it is your child who is participating in psychotherapy/play therapy, please understand that the specific content of the sessions will remain confidential. General reports of your child's progress will be made to you and any information regarding danger to your child will be reported to you immediately.

Your counselor is required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your counselor was appointed by the courts to evaluate you.
4. Your contact with your counselor is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. You are under the age of 18 years and are the victim of a crime.
7. You are a minor and your counselor reasonably suspects you are the victim of child abuse.
8. You are a person over the age of 65 and your counselor believes you are the victim of physical abuse. Your counselor may disclose information if you are the victim of emotional abuse.
9. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.
10. You file suit against your counselor for breach of duty or your counselor files suit against you.
11. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
12. You waive your rights to privilege or give consent to limited disclosure by your counselor.
13. Your insurance company paying for services has the right to review all records.

*If you have any questions about these limitations, please discuss them with your counselor.

Please review the *Policies and Practices to Protect the Privacy of Your Health Information* for a more extensive explanation of your privacy rights.

Complaints: If you have concerns or complaints regarding your treatment, you are encouraged to talk with your counselor first. You may also contact Kimberly Boyd Counseling Center, LLC 832.233.3086 by phone or email Info@KimberlyBoyd.Net to discuss your situation/concern. If there is not a resolution between you and your counselor, you may contact Texas Behavioral Health Executive Council (BHEC) The Hobby Building, Tower 3, Suite 900 333 Guadalupe Street, Austin, Texas 78701 p512.424.6500

By signing these policies, I,

(1) Acknowledge receipt of the Policies and Practices to Protect the Privacy of Your Health Information.

(2) Understand the counseling services will be provided by an independent counselor at Kimberly Boyd Counseling Center, LLC

(3) Understand and agree to the stated practice policies as listed above and

(4) Give full consent for myself or my minor child, to participate in psychotherapy. I certify that I have the legal right to seek and authorize treatment for myself or my minor child.

(5) I agree to inform the counselor of any changes in custody and inform any other guardians of the child's involvement in therapy.

_____ _____

Client/Guardian Signature **Date**

_____

Print Name

_____

Minor Client's Printed Name

_____

Legal Guardian's Printed Name

_____ _____

Legal Guardian's Signature **Date**

Client Registration

Name:_____SS#_____

Date of Birth:_____ Age:_____ Gender: Male Female_____

Address:_____

City, State, Zip_____Email:_____

Employer/School:_____Occupation:_____

Home Phone:_____Work Phone:_____Cell Phone: _____

Where do you prefer to receive calls? Home_____ Work _____ Cell _____

Emergency Contact Name and relation:_____

Address:_____Phone: _____

Individuals who live in the home:

Name	Age	Relationship

Health Information:
Please list any medical conditions you feel the therapist should be aware of:

_____

_____

Please list all medications you/client are currently taking, including the dosage:

_____

_____

Please list any known allergies: _____

Name and phone number of Primary Care Physician: _____

Permission to contact Physician? Yes No

Have you ever seen a mental health provider? Yes No

If yes, who and when: _____

Military Service: Active Former _____ Branch

Current legal proceedings? Yes No

What are your goals for therapy? _____

_____

_____

Developmental History of Clients Under Age 18:

Parent/Guardian Name:_____

Address (if different): _____

Phone number: _____ Cell:

Parent/Guardian Name:_____

Address (if different): _____

Phone Number: _____ Cell:

What languages are spoken at home?_____

How many years were parents married before birth or adoption of child? _____

In what year were the parents separated, if applicable? _____ Who has legal custody: _____

Are **you** authorized to seek counseling for this child? _ Yes _ No

What was child's birth weight? _____Were eating/sleeping patterns regular irregular?

What was child's approach to new situations: _ Positive Withdrawn Slow to warm up?

What was child's reaction to new stimuli: _ Intense _ Moderate _ Little or None?

When trying new things or encountering new situations, regardless of your child's initial reaction, would you describe your child as _ Adaptable _ Slow to adapt _ Unadaptable

Your child's activity level would be described as: _ Extreme Moderate _ Quiet

What age was toilet training started? _____ What age was it established? _____

Describe any struggles, if any, with toilet training:_____

Does the child ever wet the bed? Yes No How often?_____

Does the child wet primarily during the Night Day Both?

Does the child ever soil? Yes No.

Where is child usually when soiling or wetting occurs?_____

How is discipline handled in the home? _____

_____

Describe any traumatic events that child has been through (deaths, abuse, moves, etc.)_____

_____

List child's interests/hobbies/skills: _____

Please list any additional information which you think the counselor should know:_____

_____

_____

_____

Insurance Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the counselor insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGN HERE

_____ _____

Signature of Client or Guardian **Date**

Primary Insurance:

Name of Insured: _____ Insured's Birthday: _____

Insured's Address: _____

City, State, Zip _____

Phone: _____ Relationship to client: _____

Employer: _____ Insured SS #: _____

Insurance Company _____ Member ID#: _____

Insurance Phone #: _____

Client Name: _____

Client's Birthday: _____ Client SS #: _____

Financial Policy and Agreement

Cancellation

If cancellation is less than 24 hours in advance of your appointment, you agree to pay the cancellation fee of $110.00 for an Initial Appointment and $90.00 for follow up appointments. The same fees apply if you do not show up for your scheduled appointment.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file, the cancellation fee. _____ **Initial Here**

Insurance

Any fees not covered by your insurance company will be charged to your credit card on file. Fees include but are not limited to copayments, coinsurance, and insurance deductibles.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file, any amounts not covered by my insurance company including but not limited to copayments and insurance deductibles. _____ **Initial Here**

By signing below, I acknowledge and agree to the Financial Policy and Agreement. I further instruct my credit card issuer to honor any charges subject to the Financial Policy and Agreement.

SIGN HERE

_____

Signature of Client or Guardian

Please provide the following information:

Name on Card _____ Visa____MasterCard____Discover____Amex____

Credit Card Number _____ Exp Date _____ Sec Code _____

Billing Address _____ City _____ State _____ Zip _____

Patient Consent for Use of Email Communications

Kimberly Boyd Counseling Center, LLC has established an e-mail address for counselors for some forms of communication. For routine matters that do not require immediate response or therapeutic intervention, please feel free to email the office at **Info@KimberlyBoyd.Net**. You may also email your counselor directly. Remember however, this form of communication:

- Is not appropriate for use in an emergency
- Is a means of communication, but not a therapeutic venue

The turnaround time for routine client communication is 24 hours. The email service provider may delay message delivery. **Should you require urgent or immediate attention, this means of communication is not appropriate.**

When sending an email to Info@KimberlyBoyd.net, please

- Put your counselor's name in the subject line so it can be processed efficiently.
- Put your name and return telephone number in the body of the message.
- Use the auto reply feature to acknowledge receipt of emails coming from this office.

When sending an email directly to your counselor, you are encouraged to, but not required:

- Put the subject of your message in the subject line.
- Put your name and return telephone number in the body of the message.
- Use the auto reply feature to acknowledge receipt of emails from your counselor.

Communications relating to diagnosis and treatment will be filed in your chart.

Despite best efforts, due to the nature of email, third parties may have access to messages. All emails are maintained in the logs of your and/or our internet service providers. While under normal circumstances no one accesses these logs, they are, in theory, available to read by the system administrator(s) of the internet service provider. Additionally, when communicating from work, please be aware that some companies consider email corporate property and your email messages may be monitored.

I understand that Kimberly Boyd Counseling Center, LLC and all contracted counselors will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond control. I understand and agree to the above email policy.

By signing below, I am agreeing that Kimberly Boyd Counseling Center, LLC and all contracted counselors may send correspondence to me via email and may receive and respond to my emails via email.

Signature of Client or Guardian **Date**

Telemental Health Informed Consent

Kimberly Boyd Counseling Center, LLC

I_____, (name of client/ parent/ guardian) hereby consent to participate in Telemental health with_____(name of provider) as part of my psychotherapy. I understand that Telemental health is the practice of delivering mental health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with Telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons around me if not in a private area, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a Telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will contact you to reschedule the remainder of the appointment.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8) I understand our Telemental health sessions occur in the State of Texas, (USA), and is governed by the laws of the State of Texas.

Emergency Protocols:

Your counselor needs to know your location in case of an emergency. You agree to inform your counselor of the address where you are at the beginning of each session. Your counselor will also need a contact person whom they may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:_____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my counselor. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____	_____
Printed name of client	Relationship to minor client
_____	_____
Signature of client/parent/legal guardian	Date
_____	_____
Signature of therapist	Date