Alliance Counseling and Education Center

Kim England, LCSW
Director

Mailing Address:
1540 Keller Parkway, Ste. 108-205, Keller, TX 76248

Telephone: 800-947-7659
Fax: 940-539-9941

Interview offices:
Lewisville, Southlake and Keller

www.AllianceParenting.com

COUNSELING SERVICES ADVISEMENT FORM

Professional Disclosure Statement and Informed Consent

This document contains relevant information about our professional counseling services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. We are required to provide you with the attached **Notice of Privacy/Confidentiality Practices** and request that you sign the attached written acknowledgment that you received a copy of the notice. The notice describes how your therapist may use the information gathered during sessions in order to provide services to you. The notice also explains how your therapist may use and disclose PHI for payment or health care operations and for other purposes that are permitted or required by law. The notice also explains your rights regarding your clinical record and a brief description on how you may exercise these rights. When you sign the document attached, it will serve as an agreement between you and your counselor. You can revoke in writing this agreement at any time. Your revocation will be binding on me unless we have taken action in reliance on the Agreement, (if there are obligations required of this agency by your health insurer in order to process or substantiate claims made under your policy; or if you have an outstanding balance for service previously rendered).

If you have any questions about this notice please feel free bring them to our initial session, or contact us at (800)-947-7659**.**

Please initial at the bottom of each page of this document

Counseling- What to expect

Our counseling services of are designed to help people with individual or family concerns. It is our goal to decrease emotional distress so that clients can achieve a more positive level of functioning and experience a greater sense of well-being. Our counselors attempt to do this through play therapy, individual, family, couple and group counseling in the shortest amount of time possible. The counseling process is hard to describe in a few generalized statements. It varies greatly on the personalities of the counselor and patient, and the particular concerns you or your children are currently experiencing or have experienced in the past.

The counseling process can bring up a wide range of emotions, from exciting and energizing pleasant feelings to negative/painful feelings of guilt, anger or frustration to name a few. Emotional healing that may take place during counseling can become personally enriching and encourage you to either face a conflict or learn new coping styles. Our counselors will do everything they can to provide a positive and safe environment for you to explore the concerns that have brought you to the point of seeking counseling.

When indicated, you or your family may be referred for additional services, such as a physical examination by a doctor, medication evaluation, educations classes, or other types of therapy or support groups. Your counselor will discuss with you during your sessions these options. If your counselor is unable to provide the suggested service or you would like to consult with another counselor, your counselor will provide you with a list of referrals specific to what you are seeking.

In the event of counselor death or incapacitation, your records will be stored with another licensed mental health professional. We keep records for 7 years past the date of our last appointment.

Client/Counselor Relationship

Although sessions with your counselor may involve detailed interpersonal information, the relationship is a professional rather than a social one. This relationship functions most effectively when it remains strictly professional and involves only therapeutic aspects. Please do not invite the counselor to social gatherings, request personal references from the counselor, or ask the counselor to relate to you in any way other a professional context. Clients will be best served if sessions concentrate exclusively on their concerns.

Treatment of Minors:

Treatment of minors under the age of 18 will only be provided with the permission of the legal guardian or conservator. By signing this form for a minor client you state that you are the legal guardian or conservator of the minor client with the legal right to consent to treatment and you agree to provide a copy of current divorce/child custody order if any exists. This agency must have a copy of the current order to begin treatment.

Please initial stating that you have read and understand the above section: _____

Effects of Counseling Treatment

At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together you and your counselor will work to achieve the best possible results for you.

Client Rights

Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client (or the parent of a client), you are in complete control and may end our counseling relationship at any time, although we do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of your therapist's counseling techniques or suggestions that you believe might not be helpful.

Postponement and Termination

We reserve the right to postpone and/or terminate counseling of clients that come to counseling sessions under the influence of drugs or alcohol. We also reserve the right to discontinue counseling of clients who do not comply with the medication recommendations of their psychiatrist or doctor. If at any time, your counselor assess that you are no longer benefiting from your counseling relationship, your counselor has the right to terminate the counseling relationship after first discussing your counselor's assessment with you.

Professional Fees

All appointments are generally 45-50 minutes and are billed on a per session basis. Sessions may be scheduled for a longer period of time and in such instances are billed on a prorated basis. If you call to cancel your scheduled appointment at least 48 hours in advance you will not be charged. If you provide less than 48 hours notice, there will be a full-fee charge, emergency situations notwithstanding. Your counselor will evaluate each such circumstance and a determination as to the charge will be made at that time. Clients will not be billed for brief, miscellaneous emails or concise phone calls regarding scheduling or other questions. However, we do reserve the right to bill for excessive out-of-session communications, if that becomes a significant issue and will discuss it with you at the time should this become necessary. We do bill for any telephone conferences with you or other professionals, which require formal scheduling on our calendar. Full payment is due at the time of service as we accept cash, checks, MasterCard, and Visa. Returned checks will be assessed at a $25.00 administrative fee for each occurrence. Please check with your therapist to see if they are in network with your insurance provider.

Please initial stating that you have read and understand the above section: _____

Clinician Qualifications

By signing you are consenting that you are aware that the identified client(s) is participating in a program specifically designed for families who have children enrolled in the Keller Independent School District. You acknowledge that you are agreeable to your child being counseled by one of the following types of providers and that you are agreeable to paying the rate identified for that provider based on their sliding fee scale.

_____ Master level student—A master level student is a graduate level student either in their first or second year of the social work program. They are not licensed clinicians and are still learning therapeutic skills. Their sliding fee scale for this program is between $20.00 to $40.00 per hour.

_____ Licensed Master Level Social Workers (LMSW)—A licensed master level social worker is an individual who has completed graduate school and is licensed by the State of Texas. LMSW who are providing services at ACEC are under an approved supervision plan filed with the State of Texas. Although they are licensed by the state they are still gaining experience in utilizing therapy skills. Their sliding fee scale for this program is between $35.00 to $55.00 per hour.

_____ Licensed clinicians—Licensed clinicians are individuals who are licensed with the state to provide therapeutic services. They have completed their graduate course work and internship(s) and no longer require a supervision plan to be filed with the state. These clinicians may have multiple credentials including LCSW, LPC, or LMFT. Their sliding fee scale for this program is between $40.00 to $80.00 per hour.

_____ I understand that I cannot be involved in an active family law litigation case while on the Keller Counseling Initiative Program. I understand that if I become involved in an active family law litigation case while on the Keller Counseling Initiative Program my fee will change.

We reserve the right to suspend services if there is an unpaid balance in your account.

Court Appearances

If our counselor is to receive a subpoena then the lawyer or their staff will need to call the office and set up a time for the subpoena to be served. We request a minimum of 3 working days notice of any court appearance so that schedule changes for our other clients can be made with a reasonable time frame.

Please note: if a subpoena is received without a minimum of 3 working days notice there will be an additional $250 express charge. Failure to provide the fee as specified constitutes release from the requested appearance.

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Appearances in legal cases require clearing substantial time on our calendar as well as additional professional preparation time. For any requested appearance, subpoenaed appearance, settlement conference, or deposition the fee is $250.00 per hour, with a minimum charge of $1000.00 (four hours) due upon subpoena. Please note: if an appearance request is received without a minimum of one week notice the appearance fee is due immediately with the appearance request. Failure to provide the fee as specified constitutes release from the requested appearance.

If our counselor is subpoenaed and the case is reset with less than 48 hour notice prior to the beginning of the day of the scheduled appearance then you client will be charged the minimum four hour appearance fee.

Fees for preparation time, report writing, and production of documents (as outlined in the counseling services advisement form) may apply as well. Additionally clients are responsible for any and all attorney fees and costs that are incurred by your counselor and or Alliance Counseling and Education Center as a result of the legal action such as filing a Motion to Quash. If our counselor is requested to come to court either by you or another party you will be expected to pay for all of their professional time, including preparation and transportation costs. Because of the time and complexity of legal proceedings we require a retainer fee of $2000.00 for a full day and $1000.00 for a half day that is paid in full upon subpoena. Failure to provide the fee as specified constitutes release from the requested appearance. Any additional time/expense our counselor spends in case preparation, travel, and/ or witness time will be billed at the hourly rate of $150.00 per hour. Your counselor will only testify to the facts of the case and their professional opinion.

Contacting us and scheduling appointments

Please contact our office at 800-947-7659 to schedule appointments or request to speak to your therapist. You may leave a message at this number as the voicemail box is confidential and your call will be returned at the earliest convenience.

Our counselors ***do not*** provide 24 hour crisis counseling. Should you need immediate mental health attention, you should call 911 or go to your nearest emergency room. You may ask that your counselor be contacted from there.

It is often helpful for our counselors to use e-mail correspondence to communicate some information with you in-between sessions. The information exchanged via electronic communication is generally logistical in nature, for example scheduling and appointment changes. There are times where our counselors may email therapeutic homework assignments to clients or changes to a homework assignment.

Although Email is extremely convenient, it is inherently insecure. Once a therapeutic relationship is established, email may be used if both parties are agreeable. By you engaging in an email conversation with one of our counselors you are also acknowledging that you are aware of the possibility of inadvertent release of this information and that information sent over email is easily readable by others and can be subject to publication, although attempts are made to keep the

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information secure. In consideration of this, please do not use a work email as your main email address. Generally, messages sent through a work email are property of your employer and could be easily intercepted and read. Email will be archived in your counseling chart.

Scheduling Appointments

Clients are seen by appointment only. Sessions generally last 45-50 minutes, unless more time is agreed upon in advance. Your initial session may last a little longer since there will be a considerable amount of information to be gathered during this time. Your session is reserved for you. In the event that you will be unable to keep an appointment, please notify the office at least 48 hours in advance, so that someone else may utilize this time. Allowances will be made for emergencies, but please keep in mind that **you may be charged the full session fee for missed appointments, or appointments cancelled without 48 hour notice.**

Records and Confidentiality

All of our communication becomes part of the clinical record. Records are property of Alliance Counseling and Education Center. It is the agency policy not to release clinical records. Adult records are disposed of seven (7) years after services end. Minor client files are disposed of seven (7) years after the client's 18th birthday. In the event of the dissolution of this agency, records will be transferred and become property of another licensed counseling provider in the State of Texas.

Most of the communication with your counselor is confidential, but the following limitations and exceptions do exist:

1. We are using your case records for peer supervision, training, or professional development. In this case, to preserve your confidentiality, we will identify you by a "fake" name and identifying characteristics. (i.e. sex, marriage status, age).
2. Case consultation with staff and your counselor.
3. Your counselor determines you are a danger to yourself or someone else.
4. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person.
5. You disclose sexual contact with in the context of a professional relationship with another mental health provider.
6. Your counselor is ordered by a court to disclose information.
7. You direct your counselor in writing to release your record.
8. Your counselor is otherwise required by law to disclose information.

Our counselors follow ethical standards prescribed by state and federal law. We required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Information provided during sessions is confidential. No information will be released without the client's written consent unless mandated by law. There are some circumstances under which we are required to disclose confidential information without consent. These include but are not limited to situations where you are a danger to yourself or someone else; abuse, neglect, or exploitation of a child, elderly, or disabled person; sexual exploitation; AIDS/HIV infection and possible transmission;

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criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; fee disputes between the counselor and the client; a negligence suit brought by the client against the counselor; the filing of a complaint with a licensing board; if the counselor is ordered by a court to disclose information; or if the counselor is otherwise required by law to disclose information.

If you have any questions regarding confidentiality you should bring them to our attention when you and your counselor discuss this matter further. By signing this Professional Disclosure Statement and Informed Consent Form you are giving consent to the undersigned counselor to share confidential information with all persons mandated by law and you are also releasing and holding harmless the undersigned counselor from any departure from your right of confidentiality that may result.

In the case of marriage or family counseling, our counselors will keep confidential (within limits cited above) anything you disclose to them without your family member's knowledge. However, we encourage open communication between family members and reserve the right to terminate our counseling relationship if we judge the secret to be detrimental to the therapeutic progress. If the client is a minor we will discuss therapeutic progress with and obtain background information from all of the child's legal parents and/or guardians.

Please note that if you are raising a child between two homes and one parent requests a copy of the child's counseling records the co-parent will be notified and if desired a copy of the chart will be provided to both parents. If your case is court involved, both attorneys and or parents will be notified should a parent/attorney request a copy of the child's chart.

If you have been under the care of another therapist in the past our counselors will require permission to view and use those records in our sessions. If you are currently under the care of another therapist we are ethically obligated to confer with that counselor before beginning treatment with you.

Recording During Session

To protect your confidentiality we do not allow recording of therapy sessions of any kind including, handheld recording, video recording, or cellular phone recording during counseling sessions or telephone calls without prior written consent of you and your counselor. If you wish to record a session, please let your therapist know.

Duty to warn/Duty to protect

If our counselor believes that you (or your child if child is the client) are in any physical or emotional danger to yourself or another human being, you hereby specifically give consent to the counselor to contact any person who is in a position to prevent harm to yourself or another, including, but not limited to, the person in danger. You also give consent to the counselor to contact the emergency contacts listed on your Intake Form in addition to any medical or law enforcement personnel deemed appropriate.

Please initial stating that you have read and understand the above section: _____

Consent to treatment

By signing this Professional Disclosure Statement and Informed Consent form as the client or guardian of said client, you acknowledge that you have read, understand, and agree to the terms and conditions contained in this form. You agree you have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to you. You acknowledge voluntarily agreeing to receiving mental health assessment, treatment and services for yourself (or your child if said child is the client), and understand that you may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child and a court order has been entered with respect to the conservatorship of said child or impacting your rights with respect to consent to the child's mental health care and treatment, services will not be rendered to your child until the counselor has received and reviewed a copy of the most recent applicable court order.

Incapacity or Death

I understand that, in the event of my death or incapacitation it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to Mindy Harrison, LCSW to take possession of my records and provide me with copies at my request, and/or to deliver those records to another therapist of my choosing.

Parent Consultation Confidentiality Agreement

As a provider, for children, we routinely find it necessary to schedule parent consultations with one or both parents. Please keep in mind these consultations are NOT confidential as you are not the client. Your child is the identified client. Therefore, information discussed will become part of his/her permanent record. Your signature verifies your understanding that authorized parties may obtain information contained in your child/'s record.

Co-Parenting Confidentiality Agreement

As a provider for co-parenting, marital, and family counseling, we routinely find it necessary to schedule individual sessions with parties. Please keep in mind that because your therapist is your "co-parenting," "marital," or "family" therapist that information discussed in individual sessions is NOT confidential from other parties participating in the service. Your signature verifies your understanding of this.

PLEASE READ THE FOLLOWING CAREFULLY:

I understand payment for services are due at the end of each session or on the day of receipt of an invoice. If I do not make payment at the end of each session or upon receipt of an invoice, notice may be provided to the court, services may be suspended, and I will be charged for all attempts to seek compensation including written notices and legal fees incurred. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be utilized. Your counselor will honor contractual agreements made with those managed health care companies, which stipulate specific reimbursement restrictions.

Please initial stating that you have read and understand the above section: _____

_____
Printed Name

_____
Relationship to Client

_____
Signature

_____
Date

Please initial stating that you have read and understand the above section: _____

Alliance Counseling and Education Center

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Director

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HIPAA Compliance Standards

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE 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, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. 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, sending a copy to you in the mail upon request or providing one to you at your next appointment.

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. This will only be done with your authorization. Examples of payment-related activities

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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. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

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. For training or teaching purposes PHI will be disclosed only with your authorization.

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.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

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. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Please initial stating that you have read and understand the above section: _____

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, 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 to the program (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 document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in 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.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

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

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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 at 682-225-6990.

- **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. Please contact the Privacy Officer if you have any questions.
- **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 that you paid 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.

Please initial stating that you have read and understand the above section: _____

- **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 our Privacy Officer at 682-225-6990 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. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Please initial stating that you have read and understand the above section: _____

Alliance Counseling and Education Center
Kim England, LCSW
Director

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Directions: Please include yourself and any minor children you have legal responsibility for who will be involved in assessment, evaluation, counseling, or other services. Please use additional copies if needed.

Client(s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Alliance Counseling and Education Center's Notice of Privacy Practices, which are also available online at www.allianceparenting.com. I understand that if I have an questions regarding the Notice or my privacy rights I can contact Kim England. LCSW, the Privacy Officer for Alliance Counseling and Education Center, at the address and telephone numbers above.
Please make sure to sign both for yourself and any minor children you have legal responsibility for.

_____
Signature of Client (for self) Date

_____
Signature of Parent (for minor children), Guardian or Personal Representative* Date

_____
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Client Refuses to Acknowledge Receipt:

_____
Signature of Staff Member Date

Please initial stating that you have read and understand the above section: _____

Credit/Debit Card Pre-authorization Form

I authorize Alliance Counseling and Education Center to keep my signature on file and to make the following charges to the credit card(s) listed below. I understand my fees for services are included in my signed advisement form. I understand that this form is valid for twelve months unless I cancel the authorization in writing. My signature below confirms I will not dispute charges for services I have received.

I authorize Alliance Counseling and Education Center to charge the card on file for services rendered, per the fee schedule provided to me by Alliance Counseling and Education Center and or agreed upon and documented in discussion with my therapist or my child' s therapist.

I authorize Alliance Counseling and Education Center to charge my credit card for sessions that I do not show to as scheduled and for sessions that I do not cancel or reschedule 48 hours prior to my scheduled appointment.

I understand information must match the card or it will not process. I understand I am to notify Alliance Counseling and Education Center as soon as possible if any of this information changes.

Client' s Name					
Cardholder' s Name					
Cardholder' s Address					
City		State		Zip	

Circle One

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card #	Expiration Date
Billing Zip Code for Card	
Verification # (found on back of card)	

Signature of Client/Legal Guardian Date

Please initial stating that you have read and understand the above section: _____