PRACTICAL SOLUTIONS
COUNSELING & CONSULTING, PLLC

Please complete all parts of this page.

Demographic Information

Client name: _____ Date: _____

Marital Status: M | S | D | W DOB: _____

☐ Check box if interested in Practical Solutions Counseling & Consulting, PLLC's monthly newsletter with news, workshops, and articles via email.

Client Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

May we leave a message on your phone? ☐ Yes ☐ No
May we send a text message to your cell phone? ☐ Yes ☐ No
May we send reminders to your email? ☐ Yes ☐ No

***NOTE**: Email correspondence and texts are not guaranteed as a confidential method of communication. If you choose to use it, please limit to details like scheduling.

Primary Insurance/Policy Number/Group Number: _____

Secondary Insurance/Policy Number/Group Number: _____

Policy Holder's name/relationship: _____ DOB: _____

Policy Holder's address: _____

Emergency contact/Guardian information: _____

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COUNSELING & CONSULTING, PLLC

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Providers:

Primary Care Physician/Pediatrician: _____ Phone Number: _____

Psychiatrist/Psychiatric NP: _____ Phone Number: _____

Additional Information:

What are your presenting issues?

_____

_____

Please list any medical conditions (client): _____

_____

_____

Please list any prescription medication/doses:

_____

_____

_____

How were you referred to Practical Solutions Counseling & Consulting, PLLC? _____

_____

PRACTICAL SOLUTIONS
COUNSELING & CONSULTING, PLLC

Outpatient Services Contract

Welcome to Practical Solutions Counseling & Consulting, PLLC. Since this is your first visit, we hope that what is written here can answer some of your questions as you seek therapy. Please let me know if you want clarification on any of the topics discussed in this paperwork, or if you have any questions that are not addressed here; feel free to discuss with us at any time. The therapeutic relationship is unique in that it is a highly personal and a contractual agreement. Given this it is important for us to reach a clear understanding about how our relationship will work and what each of us can expect.
This consent will provide a clear framework for our work together. Please read and indicate that you have reviewed this information and agree to it by initialing on each ling and signing at the end of the document. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

_____**Psychotherapy Services:** We provide psychotherapy services to children, adolescents, and adults. The first appointment(s) serve as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about you and current life situation. If you do not agree with our treatment recommendations or do not feel that the personality style will be a good match for you, let us know, and will do our best to provide alternatives.
The step to seek therapy is a positive step in the therapeutic process. It takes work both in and out of session to be most effective and requests involvement, honesty, and openness in order to change thoughts, emotional reactions, and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication, stability in relationships, and lessening of distress. Some potential risks include increased emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Although there are many benefits to therapy, there is no guarantee of positive or intended results.

_____**Confidentiality:** Please know that there may be times that we see each other in public. To protect your confidentiality, we will not acknowledge you until you acknowledge us. Speaking about clinical matters is not recommended in a public setting and should be reserved for your session.
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests, in writing, to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

PRACTICALSOLUTIONS
COUNSELING & CONSULTING, PLLC

- If we believe that a client is a serious threat to harming him/herself, we must take protective action (arranging hospitalization, contacting family/significant others for notification, and/or contacting the police).
- If a client threatens serious harm or death to another person or property, we must take action (through notifying the potential victim, the police and/or facilitating hospitalization of the client).
- If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 (appropriate state agency-DHS or law enforcement will notified according to mandatory reporting laws).
- Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
- Suspected neglect of children, vulnerable adults, and/or elderly persons.
- If a court of law issues a legitimate subpoena for information stated on subpoena
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

_____**Consultation:** Occasionally, I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

_____**Professional Records:** Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information be released.

_____**Social Media Policy:** If you choose to email or text us, please limit contents to issues, such as scheduling. Please do not contact us via email or text messages regarding clinical issues as they are not guaranteed confidential. Occasionally, we may send you an article or link that might be useful to you. If you choose to communicate with us this way, you do so understanding that I cannot guarantee that these modes of communication are confidential. For this and other ethical reasons, I do not accept invitations from current or former clients via social networking sites, such as but not limited to LinkedIn, Facebook, or Instagram.

_____**Insurance:** If you choose to use your insurance for payment, please note that a mental health diagnosis is necessary on the form for reimbursement. If I accept your insurance, I can submit the bill for you. If I am out-of-network with your provider, we will obtain payment from

PRACTICALSOLUTIONS
COUNSELING & CONSULTING, PLLC

you and provide you with a 'superbill' to submit for reimbursement. As a courtesy, we check benefits for our clients. However, there are times when insurance misquotes benefits. In the event of a misquote, clients are still responsible for copay/coinsurance/deductible amount that insurance reports after claims are submitted. **Clients are encouraged to call their insurance company to check their own benefits – contact number on the back of your insurance card.** We also provide online therapy sessions and some insurances cover tele-therapy. If your insurance plan does not cover tele-therapy services, our full fee applies.
Fees are reviewed annually and an increase of $5 per year applies to our rates every January 1st.

_____**Late Cancelation:** If you need to reschedule, please call me as soon as possible. Since we hold a spot for you and make it unavailable for someone else, a $60 cancelation fee may apply to appointments canceled less than 24 hours. If you do not show for a scheduled appointment with a cancelation call, you will be charged the full fee for the missed session. All reschedules or cancelations must be done through calls (emails or not acceptable). Payment for the cancelation is required prior to rescheduling the appointment. We are aware that emergencies arrive and may make an exception to the late fee based on circumstances. A client may be discharged from services if there are 2 'no shows' within a 90 day period. A preferred appointment time may be removed and available to others if there are 2 'late cancels' in a 90 day period.

_____**Court Related Services:** We do not provide or perform evaluations for custody, visitation, or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation, or fitness of a parent in any legal matters or administrative proceedings.
If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

- We charge a $1500 retainer prior to any preparation or attendance of legal proceedings.
- We charge $200/hour to prepare for and/or attend any legal proceeding and for all court related services.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions, and court appearances.
- If the court or attorneys do not pay for our fee, you will be charged for the time we spend responding to legal matters.

15465 Oak Lane, Suite 100G | Gulfport, MS 39503 | 228-314-3626 | practicalsolutionspllc@gmail.com

PRACTICALSOLUTIONS
COUNSELING & CONSULTING, PLLC

- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

_____**Duration and Termination:** Many clients come weekly or every other week. Committing to and prioritizing that time is ideal. Occasionally, people attend therapy more often or reduce the frequency once things improve. Sometimes it becomes clear that a different approach or level of care is best or necessary. If I initiate terminating therapy with you, it will be because I feel that I am not able to be helpful or a higher level of care is needed. My ethics and license requires that I have my clients' needs as primary in treatment planning. If I feel that I am no longer the right resource for you, I will offer additional referrals to other sources of care, but I cannot guarantee that they will accept you or how they will approach your needs. Ending therapy well is important. Length of counseling varies and is up to the client and treatment needs however, please let me know if you feel ready to complete this course of counseling.
Once you have stopped attending and after 60 days of no contact, you are no longer under my care and our therapeutic relationship will be ended unless you re-initiate treatment with me.
If during our work together with your therapist, lack of participation with treatment recommendations becomes an issue, we will make effort to discuss this with you to determine the barriers to treatment completion. At times, lack of participation in treatment may necessitate termination of therapy services. We encourage you to discuss any concerns you have about our work together directly so that we can address them in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats towards us or refusal to pay for services after a reasonable amount of time and attempts to resolve the issue.

_____**Telephone and Emergency Procedures:** There are times when telephone contact is necessary between sessions. Clients are encouraged to keep telephone contact brief, if possible, and to address issues during your regular therapy sessions. Phone calls may be billed at a pro-rated cost at 15 minute intervals. This charge is not covered by insurance and the client (or parent) will be responsible for the cost.
If you need to speak with us between sessions, please call 228-314-3626 and your call will be returned as soon as possible.
Practical Solutions Counseling & Consulting, PLLC is not a crisis center. If necessary, the Suicide Prevention Lifeline can be contacted at 800-273-8255. If you require immediate attention, you agree to call 911 or go to your nearest emergency room.

PRACTICAL SOLUTIONS
COUNSELING & CONSULTING, PLLC

_____**HIPAA:** I understand that Practical Solutions Counseling & Consulting, PLLC adheres to the privacy practices outlined in the HIPAA National Providers Policy available for review in my office. Typically state and license confidentiality regulations are far more stringent, so the most restrictive standard is adhered to for therapy.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____
Client's name

_____ _____
Client's signature Date

_____ _____
Parent/Guardian's signature Date

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NOTICE OF PRIVACY PRACTICES:
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MY PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal and we are committed to protecting your health information. We create a record of the care and services that you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records you care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that **protected health information ("PHI")** that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information that we have about you.
- The new Notice will be available upon request, in our office, and on the website.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give examples. Not every use or disclosure in a category will be listed however, all the ways we are permitted to use and disclose information will fall within one of these categories.

- For treatment payment or Healthcare operations – Federal privacy rules/regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal information without the client's written authorization, to carry out the healthcare provider's own treatment, payment, or healthcare operations.
- We may also disclose your protected health information for the treatment activities of any healthcare providers. This too can be done without your written authorization. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other healthcare providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment"

includes, among other things, the coordination and management of healthcare providers with third party, consultations between healthcare providers and referrals of a client for healthcare from one healthcare provider to another provider.
- Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order, or in a response to a subpoena.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:
- Psychotherapy notes – We may keep "psychotherapy notes" as that term is defined in 45 CFR 164.501, and any use or disclosure of such notes require your AUTHORIZATION unless the use or disclosure is: a) for my use in treating you; b) for our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy; c) for our use in defending ourselves in legal proceedings instituted by you; d) for use by the Secretary of Health and Human Services to investigate my compliance with HIPAA; e) required by law and the use or disclosure is limited to the requirements of such law; f) Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes; g) Required by a coroner or medical examiner who is performing duties authorized by law; h) Required to help avert a serious threat to the health and safety of others
- Marketing purposes – As a practice of psychotherapists, we will not use or disclose your PHI for marketing purposes. You are able to choose to receive emails/newsletters from this practice.
- Sale of PHI – As a practice of psychotherapists, we will not sell your PHI in the regular course of business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:
Subject to certain limitations by the law, we can use and disclose your PHI without your authorization for the following reasons:
- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or vulnerable adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order.
- For law enforcement purposes, including reporting crimes that occurred on our premises

- To coroners, medical examiners, or funeral directors, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing mental health of clients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including ensuring the proper execution of military missions, protecting the President of the United States, conducting intelligence or counter-intelligence operations, or helping to ensure the safety of those working within or housed in correctional institutions.
- For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
- Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment. I may also use and disclose your PHI to tell you about treatment alternatives or other healthcare services or benefits that we offer.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

- Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

- The Right to Request Limits on Uses and Disclosures of your PHI: You have the right to ask me not to use or disclose certain PHI for treatment, payment, or healthcare operations purposes. We are not required to agree to your request and we may say 'no' if we believe it would affect healthcare.
- The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full: You have the right to request restrictions on disclosures of your PHI to health plans for payment or healthcare operations purposes if the PHI pertains solely to a healthcare item or a health care service that you have paid for out-of-pocket in full.
- The Right to Choose How We send PHI to you: You have the right to ask me to contact you in a specific way (for example, home or cell phone) or to send mail to a different address and we will agree to all reasonable requests.

PRACTICALSOLUTIONS
COUNSELING & CONSULTING, PLLC

- The Right to See and Get Copies of your PHI: Other than "psychotherapy notes", you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record or a summary of it, if you agree to a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
- The Right to Get a List of Disclosures we have made: You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or healthcare operations, or for which you have provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last 6 years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.
- The Right to Correct or Update your PHI: If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
- The Right to Get a Paper or Electronic Copy of this Notice: You have a right to get a paper copy of this Notice and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
- The Right to Choose Someone to act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has the authority and can act for you before we take any action.
- The Right to File a Complaint if you feel your rights were violated: You can file a complaint if you feel we have violated your rights by contacting us at 228-314-3626. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Ave, S.W., Washington D. C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints

PRACTICALSOLUTIONS
COUNSELING & CONSULTING, PLLC

For more information, go to: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.htm

Changes to the Terms of this Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.
BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____
Client's name

_____ _____
Client's signature Date

_____ _____
Parent/Guardian's signature Date