INFORMED CONSENT &
HIPAA/HITECH ACKNOWLEDGEMENT OF RECEIPT

CATHY T. BURNS LPC-S
Licensed Professional Counselor
4211 I-40 West Suite 101
Amarillo, TX 79106
Phone: 806-350-5867 Fax: 806-358-4345

GENERAL INFORMATION: My name is Cathy T. Burns. I have a Masters degree in professional counseling and I am a Licensed Professional Counselor in the State of Texas under the occupations code, chapter 503 which allows me to provide individual, couples, family and group services. I work with individuals, couples, and families dealing with various issues. I also have a Bachelor of Science degree and Health Care Science and I am a Physician Assistant as well as having other additional credentials such as additional training as a Spiritual Director, premarital and marital intensive counselor.

I work with individuals, couples, and families from across the lifespan dealing with various issues in their lives. I also facilitate a chronic illness support group. Although I am capable of handling a variety of problems, there may be situations that I will recommend you to another specialized therapist so you will be better served. Please note that I am not a Psychiatrist, (who is a medically trained doctor), so I am unable to prescribe medication. Also, I am not a Licensed Psychologist and I am unable to administer certain diagnostic tests.

My approach is an empathetic talk therapy approach that incorporates multiple therapeutic interventions such as Family Systems, Marital (if married), Contextual, Cognitive/Behavioral, Solution Focused, Emotion Focused and Reality Therapy Models. My foundation is Christian based, and will seek to incorporate the faith of the clients along with aspects of spiritual formation such as prayer, bible study, worship, service, small groups, etc. into the therapeutic interventions. PLEASE NOTE I strive be aware of the client's stance regarding Christianity and will at no time impose my beliefs. My foremost concern will be to provide a safe environment to journey with a client being respectful of their needs while guiding them to a place of emotional healing.

In addition to your confidentiality being important I am ethically bound to keep the information confidential. **If I should meet you in public, please know I will not acknowledge you unless you initiate contact. It is preferred that you decide whether or not to disclose your acquaintance to others.**

SESSION INFORMATION AND FEES

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Group sessions are approximately 90 minutes long. If you must cancel or reschedule your appointment, please call the office at 806-350-5867 at least **24** hours in advance. Appointments that are not cancelled at least 24 hours in advance will be **charged** to your account.
Due to our confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical emergency a note will be make on the account without disclosing information to a third party or family member unless a release is on file.

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PAYMENT/INSURANCE FIING: Your first initial visit will be an assessment session in which you and I will determine your concerns, and if we both decide that I can provide your therapeutic needs, then we will work on treatment objectives together. The fee for a LPC-S initial session is $150.00 (filed as a 90791). The fee for regular 50 minute sessions thereafter is $130.00 (filed as a 90834). I do not charge for time spent on case notes or appointment preparation. The fee for group therapy is $35.00 per 90 minutes. For a LPC- Intern the sessions are $75 (50 minutes)and insurance **will not be filed**. There may be other fees assessed for separate profiles or educational materials.

In unusual cases, you may become involved in litigation that may require my participation. You will be expected to pay for the professional time required for my participation at a rate of $200.00 an hour.

I will try to work with you on fee payment if necessary, but I appreciate payment for each session. It is best to pay with cash or a check at the beginning of each session. Checks can be made out to Cathy T. Burns, LPC. I also accept Visa or MasterCard. Payment is expected at the time you arrive for your session and subsequent sessions will then be scheduled at the conclusion of that session if determined necessary. By signing this agreement you understand that you are fully responsible for all fees.

For those being referred to me that have been provided scholarship by your church, strict confidentiality will be monitored and only the minimum necessary protected health information will be released for the supplemented funds.

In some cases, treatment will qualify you for insurance payment. If you wish to file with your health insurance for therapy costs, I am considered out of network with most insurance companies. Full payment is required until insurance information can be established. Most insurance companies require that I provide a mental health diagnosis to a client before they will consider payment and then require consultation to approve sessions. Also, relationship issues such as parent/child or marital counseling usually do not qualify for insurance payments.

Payment of fees, including any required co-pays that are established, is expected at the time of each appointment in full. I request that payment be made before your session begins. If you are using insurance benefits, Cathy Burn's LPC billing services will file insurance claims for you, and will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, full payment at the time of service is expected and a receipt or statement for services rendered will be provided to you. **Most insurance companies require that I give a mental health diagnosis to a client before they will consider payment and then require consultation to approve sessions. I feel that this activity compromises client confidentiality.**

The billing service will follow up on all collection of monies not received from the Insurance companies. By signing this agreement you are agreeing to pay for any services rendered which are not paid by your insurance company.

MINORS: Minors must have parental consent for counseling with the exception that the client: is 16 years of age or older and resides apart from the parents/guardians and manages his/her own financial affairs; is thinking about suicide; has concerns about alcohol or drug addiction/dependency; or is being sexually, physically, or emotionally abused. Consenting parents have the right to examine the treatment records of children under the age of 18; however, in order that minors may have the trust of a protected environment, it is your counselor's practice to ask parents to forego that right (they are willing to discuss progress with the parent/guardian) with the exception of extreme

circumstances (see confidentiality above).

At the termination of treatment and upon request, your Counselor will provide the parent(s)/guardian(s) with a summary of treatment. It is important to note that in the state of Texas children under 17 may not have consensual sex (by law it is considered indecency with a child and therefore "child abuse") and the state requires a therapist to breach confidentiality and report such activity to Child Protective Services. If your counselor is required to make such a report to CPS about your child, you will be informed as well.

VIDEO TAPING:In order to provide the highest level of care to clients, your counselor may video/audio tape your sessions for review and consultation. Again, this information will be kept confidential and you will be informed if this should take place.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS: This includes but is not limited to the following: Email, Skype (or any other face time service), chat, mobile devices, cell phones or fax. . Please know our office will maintain your confidentiality to the best of our ability; however we cannot guarantee this with any electronic communication.

If you choose to email me from your personal email account, please limit the contents to pragmatic issues such as cancellation or change in contact information. If choose to include personal and/or clinical concerns please know you may be charged applicable fee's for a session

In the event you are contacted or place a call to our staff, please be aware that unless we are both on land line phones, the conversation is not considered confidential and it is possible that your PHI/ePHI could be exposed. Likewise, text messages are not confidential and it is not advised nor appropriate to converse about personal issues or concerns via text. That is what our face to face sessions are for.

If you wish to use email as a way to "journal" information between sessions, you understand that your counselor may not have the opportunity to review your journal emails until your next scheduled session.

I will make every effort to keep all information confidential. Likewise, it is important that you carefully determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. Please only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured.

Be sure to fully exit all online counseling sessions and emails. If you are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, call 806-350-5867 to schedule a new session time.

DUAL RELATIONSHIPS & SOCIAL NETWORKING: Not all dual relationships are unethical or avoidable. However, dual relationship situations might impair your counselor's objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged.

Please be aware that our social networking sites are utilized as a "blog" and not intended to replace personal counseling sessions. In regards to your counselor's personal social networking sites, your counselor may choose not to accept your invitation in the interest in protecting your privacy.

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RELEASE OF INFORMATION: If information needs to be released it will only be done according to state law and with a written consent from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties consent in writing or if mandated by the court.

INCAPACITY OR DEATH: In the event of the incapacitation or death of myself, it will be necessary to assign your case to another counselor and for that counselor to have possession of your treatment records. By your signature on this form, you are consenting to another LPC/LPC-Supervisor, LPC-Intern, which are personally chosen colleagues preferred by myself, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LPC Intern of your choosing.

AVAILABILITY: It is my desire to provide the highest level of care to clients both inside and outside of sessions. For scheduling and non-emergency situations, please contact me at 806-350-5867. In the event you encounter a personal emergency which will require prompt attention, I will make every effort to accommodate and appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call the Crisis Line at 806-359-6699 or Family Support Services at 806-342-2500, call 911 or go directly to the nearest emergency department.

MODIFICATION AND CONFLICT RESOLUTION: It is agreed that any disputes or modification of agreement shall be negotiated directly between the therapist and client(s). If these negotiations are not satisfactory, then the therapist client(s) agree to mediate any differences with a mutual acceptable third-party mediator, consisting first of another therapist of the practice. If these negotiations are unsatisfactory, the parties shall move to arbitration and then binding arbitration, choosing an arbitrator mutually agreeable by both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory.

RISKS & BENEFITS: It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his/her life. Therapy is designed to assist clients in resolving issues and dealing with painful life problems. Your counselor will make every effort to make therapy successful in this manner; however, you should know that therapy is no guarantee that you will "solve" your problems and that issues will be resolved. Furthermore please be aware, that through the course of therapy, we may expose issues that may cause additional problems to you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between counselor and client as soon as possible.

CONFIDENTIALITY: Discussions between a Therapist and a client are generally confidential and protected by law. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board.

If you have any questions regarding confidentiality, you should bring them to my attention so that we can discuss this matter further. I hold confidentiality between clients in the highest

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regard and will make every effort to protect information shared in our session together. By signing this Information and Consent Form, you are giving consent to Cathy T. Burns LPC to share confidential information with all persons mandated by law, with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name Telephone Number

_____ _____

_____ _____

HIPAA/HITECH: I am are required by law to maintain the privacy of and provide individuals with a copy of our "Notice to Privacy Practices" of our ethical and legal duties in regards to your protected health information in all forms (i.e. all paper and/or electronic data). A copy of this notice is on our website, attached with this informed consent and available in paper form. A copy will be provided to you at no cost upon your request. If you have any objections to the Notice, please ask to speak with my HIPAA/HITECH Certified Office Administrator in person or by phone 806-355-4673.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I agree to participate in therapy with Cathy T. Burns M.A., LPC. I authorize Cathy T. Burns' billing services to file insurance on my behalf, if applicable, and assign payments directly to Cathy T. Burns LPC I understand that if my insurance does not pay for my sessions, I am responsible for the payment of those services.

I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if 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, Cathy T. Burns M.A. LPC will not render services to your child until the she has received and reviewed a copy of the most recent applicable court order.

You have my permission to call phone number(s)_____regarding my appointments

_____ _____

Signature - Client/Parent Date

_____

Print - Client/Parent

_____ _____

Therapist Date

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To this office's:
Notice of Privacy Practices

Cathy T. Burns LPC-S

4211 I-40 West Suite 101
Amarillo, TX 79106
Phone: 806-350-5867 Fax: 806-358-4345

Printed Client's Name: _____
Client's Birth Date: ____/____/____

The Office of Cathy T. Burns required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/ Electronic Protected Health Information). This notice is located on our website and in paper format with our informed consent. You may also receive a paper copy at no charge upon your request. If you have any objections to this notice, please ask to speak with or leave a message at 806-355-4673 for my HIPAA/HITECH Certified Office Administrator.

I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practice Document.

_____ ___/___/_____
Signature of Client, Client's Representative or Parent/Guardian Date

_____
Relationship if you are the Client's Representative or Parent/Guardian

_____ ___/___/_____
Office Staff Signature as witness Date