Consent for Treatment

I, _____, herby give Bell Counseling Services, PLLC permission to perform treatment or service for chemical dependency. I understand the nature and purpose of:

1. The treatment will be for chemical dependency.
2. The proposed treatment of services may include the following: alcohol/drug education, smoking cessation, life skills, and development of coping skills needed to maintain long-term abstinence through utilization of community support networks, discharge plan, and referral for other services, as needed.
3. The expected benefit for you is that you will develop a way of living free of abuse and use of addictive chemicals.
4. The probable health and mental health consequences of not consenting may include but are not limited to: destruction of family unit; decline of physical and mental health and further loss in socio/economic status.
5. The side effects of risk associated with the treatment may include but not limited to: increased short term symptoms of anxiety and depression and emotional discomfort; major current life style changes both positive and negative.
6. When the client or counselor believes that the client cannot make positive changes in their program, they may be referred to other social services agencies that could more appropriately meet their needs.
7. You and counselor will determine the appropriate course of your treatment.
8. Client Grievance Procedure will be provided, reviewed and discussed during New Client Orientation.
9. Client Bill of Rights will be provided, reviewed and discussed during New Client Orientation.
10. Client Program Rules will be provided, reviewed and discussed during New Client Orientation.
11. The Client Contract for Treatment and Informed Consent, including circumstance that may lead to immediate discharge will be provided, reviewed and discussed during New Client Orientation.
12. Non-compliance of programmatic rules may lead to reporting to your referral source and/or transfer to a higher level of cares; Non-compliance may lead to immediate discharge form the program.
13. The cost of services will be discussed and receipts given with ALL payments.
14. Client will be given the opportunity for family involvement for individual counseling sessions, group counseling and education lectures throughout course of treatment.

I understand and have received a copy of the Client Bill of Rights, the Client Grievance Procedure, Program Rules, Client Contract for treatment and Informed Consent. I agree to abide by the rules and participate in the defined treatment plan.

_____ Date: _____
(Client Signature)

_____ Date: _____
(Counselor Signature)

CLIENT RIGHTS

1. I understand I have the right to treatment, and that I am voluntarily seeking services.

2. I have the right to individual privacy and respect. My addiction or other problems do not diminish my essential worth as a human being.

3. There will not be any prejudicial treatment as a result of age, sex, race, religion, or cultural background.

4. I have the right to know my diagnosis, evaluation, goal of treatment, and the methods recommended to attain this goal. In fact, I will be involved in establishing my treatment goals.

5. If I am not satisfied in any way with answers or treatment given, I have the right and responsibility to seek treatment elsewhere.

6. I understand my right to confidentiality includes the following:

A. That my presence in therapy is not to be disclosed to anyone without my permission.
B. No portion of my clinical records may be disclosed to anyone without my permission.
C. That my condition, progress, or any other information concerning me may not be disclosed to anyone without my permission.
D. By law, all suspected cases of child, disabled, or elder abuse/neglect must be reported to the Department of Children & Families.
E. Therapist is required to warn individuals whose lives are known to be in danger.

7. I have the right to report client abuse by calling this number:

Department of State Health Services
Substance Abuse Compliance Group
P. O. Box 149347
MailCode 1979
Austin, TX 78714-9437
1-800-832-9623 or FAX 1-512-834-6638

The contact for TDCJ is:

Texas Department of Criminal Justice
8610 Shoal Creek Blvd
Austin, TX 78741
512-406-5758

Client signature: _____ Date: _____

CLIENT EXPECTATIONS

1. Maintain regular and consistent attendance.

2. Show evidence of motivation to change and to participate.

3. Remain alcohol and drug free, or work at a specifically developed Responsible Drinking Treatment Plan.

4. Treatment will be extended if unable to maintain abstinence or comply with other treatment expectations. YOU ARE RESPONSIBLE TO MEET THE TIME DEADLINES ON YOUR TREATMENT PLAN.

5. For D.W.I. related substance abuse counseling you are expected to:
   A) Attend counseling regularly
   B) Go to self-help meetings
   C) Stay sober

6. Be responsible for payment at time of services.

7. Free copies are provided for customary reports- mailed or faxed copies are $5.00 up to 5 pages, and $1.00 per page thereafter.

8. Generally accepted hygiene practices are encouraged and a copy of infection control policies is available.

9. There shall be no violence or threats of physical violence in group settings.

10. Other individuals' confidentiality must be respected. No discussion of other individuals outside the group setting is acceptable.

11. These rules were designed to foster the safety and trust necessary for a positive therapeutic environment.

12. Prescription drug use must be reported and verified by your prescribing doctor.

Client signature: _____ Date: _____

Bell Counseling Services

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Texas. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Counselor determination that you may harm yourself or someone else.
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled.
- Disclosure of professional misconduct of another mental health professional.
- Court order or requirement by law to disclose information.
- Prenatal exposure to controlled substances.
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records).
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records).

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

Client Name (please print):_____

Client Signature: _____ Date: ____/____/_____

Counselor Signature_____ Date: ____/____/_____

Grievance Procedure Orientation Form

Clients have the right to lodge a grievance or any complaint against the counselor about abuse, neglect and exploitation.

You may complain directly to the counselor. You may submit your complaint verbally or in writing, you may have assistance in writing the complaint if you are unable to write. You may grieve directly at any point in the grievance process to:

Texas Department of State Health Services-Substance Abuse Compliance Group
P. O. Box 149347
Mail Code 1979
Austin, Texas 78714-9437
1-800-832-9623 or FAX 1-512-834-6638

The contact for TDCJ is:

Texas Department of Criminal Justice
8610 Shoal Creek Blvd
Austin, Texas 78741
512-406-5758

Pens, paper, envelope, postage, and access to a telephone will be provided upon request in order to file a complaint.

All unresolved complaints shall be forwarded to the Texas Department of State Health Services.

_____ Date: _____
(Client Signature)

_____ Date: _____
(Counselor Signature)

Grounds for Discharge

1. Clients must not be under the influence of any substance (alcohol or drugs) at the time of the session. **To do so, would lead to immediate termination of services.**
2. Fighting, cursing in anger or verbal arguments will result in disciplinary action, which may result in termination.
3. Romantic relationships between clients or exclusive friendships are strongly discouraged. Pairing of, isolation with another client, intimate touching, etc. do not enhance the recovery process and are grounds for disciplinary action and could result in termination form the program.
4. Theft or vandalism of any sort, whether the property of another client, will result in immediate termination and will be reported to law enforcement officials.
5. Any combinations of three (3) restrictions/sanctions indicate an unwillingness to change or to abide by society's result and will result in sanctions to include immediate and unsatisfactory discharge from this program.

I have read and understand the grounds for discharge.

_____ Date: _____
(Client Signature)

Bell Counseling Services

Notice of Privacy Practices (HIPAA)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

•**Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
• **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 1, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information at the address found at the bottom of this page.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: (877) 696-6775

Notice of Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information

When we (NPCS and Subcontracted Therapists) consult, evaluate, diagnose, treat, and/or refer you (the client or minor client that you represent), we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read this notice and are aware our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information is available to you upon request.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do accept them, we commit to abide by the limitations that you have requested. After you have signed this consent, you have the right to revoke it by submitting a written request to our Office Manager. Upon receipt of your request, we will discontinue using or sharing your PHI.

However, please be advised that we may have already used or shared some of it, and that information cannot be retracted.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the

Bell Counseling Services, PLLC
Notice of Private Practices.

Client Name (please print):_____

Client Signature: _____ Date: ____/____/_____

TREATMENT PLAN

Client Name_____ Clt. # _____

Problem #1

Goal _____

Intervention: _____

Measurable Change: _____

Problem #2

Goal: _____

Intervention: _____

Measurable Change: _____

Problem #3

Goal: _____

Intervention: _____

Measurable Change: _____

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

BELL
COUNSELING
SERVICES

Attention: Private Pay Clients

If you are listed as a "private pay client" or if adult probation is paying a partial payment (referral) for your counseling; ALL payments must be completed by the last counseling appointment/discharge date.

If your payment has not been completed by this time; YOU will be considered INCOMPLETE, in terms of your counseling obligations.

By signing below, you are acknowledging your awareness and understanding of these terms:

Name: _____

Date: _____

Staff signature: _____

Date: _____