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Office Policies and Informed Consent

I am pleased to have the opportunity to work with you and hope that this handout will provide information helpful in making an informed decision concerning my services. If you have any questions or concerns about these policies or any other aspect of this practice, please feel free to discuss them with me at any time.

Fees and Payment: My standard fee is \$160 per 50-minute session. Variations are prorated from the basic fee. Payment for services should be received at the time they are provided unless other arrangements have been made. Check, cash or credit card/debit card is fine.

Cancellations: A minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. Clients will be charged for missed sessions without such notification unless it is due to an emergency. Please remember that many insurance companies do not provide payment for missed sessions; therefore, you would be responsible for the entire fee determined by the insurance company.

Message Service: You may leave a message with my voice mail if you need to reach me at 577- 9932. Messages left after regular business hours will generally be returned the following business day.

Emergencies: In the event of an emergency, please make use of the emergency services listed below:

24-hour Crisis Hotline	472-HELP
Seton Psychiatric Emergency Department 601 E 15th St, Austin, TX 78701	324-7000
General Emergency	911

Unpaid Accounts: If you experience difficulty meeting your fees please contact me so we can establish a reasonable payment plan.

Licensing: As a LPC license holder, I adhere and am bound by the provisions of the Licensed Professional Counselor Act and the Texas State Board of Examiners of Professional Counselors Board Rules. You may contact the Texas State Board of Examiners of Professional Counselors to report violations, complaints, and concerns:

Texas State Board of Examiners of Professional Counselor
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6658

Confidentiality

The privacy and confidentiality of our sessions are extremely important to me. To the degree allowed by the law, information about your contact with me will not be disclosed to any person or organization unless you give me a specific, written release to do so. While you are free to discuss anything that occurs in our sessions with anyone, I am required to obtain your written authorization. In all aspects of this practice, communication is protected by federal and state confidentiality laws as well as by professional standards and ethics.

There are some situations written into law that deny me complete control over confidentiality of communication as follows:

1. Legally, I must report any situation of suspected child abuse or neglect to the proper authorities. I must also report if abuse, neglect or exploitation of an elderly or disabled person is suspected.
2. The court in some circumstances may subpoena records. In particular, confidentiality may be waived in any suit affecting the parent-child relationship.
3. If I have reason to believe that a client may harm him or herself, or another individual, I am permitted by law to break confidentiality by contacting law enforcement officials and/or medical authorities who may then take protective actions.
4. If a client discloses to me the identity of a mental health professional who engaged in sexual contact with him or her during the process of treatment, I am required by state law and code of ethics to report that professional to the appropriate authorities.
5. Confidentiality does not extend to criminal proceedings in Texas.
6. If I am contacted by an insurance company or an auditor, I may be required to release client information as dictated by law. The law also permits me to release information to a collection agency in order to collect on an overdue account.

This list is not exhaustive; however, these are the most common circumstances that could occur. The situations described are certainly out of the ordinary and often do not impact the majority of individuals receiving professional services.

If You Are Using Insurance: It is important to understand the mental health services your insurance policy covers. Please be aware that there are some concerns, struggles and issues that clients bring to therapy that are not covered. If this is the case, then you would be responsible for payment and the fee charged will vary depending on your insurance policy. Of course, I will be happy to help in understanding the information you receive from your insurance company.

Some insurance plans require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work on specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. If this occurs you have the option of continuing by paying independently. The fee charged will vary depending on your insurance policy and my contract with them (some policies require a continuation of the maximum allowance and other allow me to charge my standard fee).

Please also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. We will discuss this beforehand. Occasionally, I have to provide additional information such as treatment plans or summaries or rarely copies of the entire record. The information will become part of the insurance company's files and part of your medical record that may be shared with others in the insurance industry.

HIPPA: The Health Insurance Portability and Accountability Act (HIPPA) is a federal law that provides new privacy protections and new 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. HIPPA requires that I provide you with a "Notice of Policies and Practices to Protect the Privacy of Your Health Information" for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which accompanies these Office Policies, explains HIPPA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. I am always willing to discuss any questions you have about the procedures at any time.

HIPPA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of these Office Policies, the accompanying Notice of Privacy Practices, and my privacy policies and procedures.

I hereby grant my permission for counseling services or any diagnostic evaluation that may be deemed necessary by my therapist. I understand that therapy is a joint effort between the therapist and client. I have read and understand the office policies described above and have been given the opportunity to ask any questions concerning the limits of confidentiality. I have reviewed this office's "Notice of Policies and Practices to Protect the Privacy of Your Health Information" and have received a copy.

Client Signature _____ Date _____

Please sign if you are using insurance: I authorize Cathy Fariss to release any medical or other information necessary to process insurance or managed care claims. I authorize payment of medical benefits to Cathy Fariss for all mental health services provided.

Client Signature _____ Date _____