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PROFESSIONAL DISCLOSURE STATEMENT AND CLIENT CONSENT FORM

Welcome to my practice. This document (the Agreement) contains important information about my professional 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. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. My practice is in general accordance with HIPAA policies. 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. We can discuss any questions you have about the procedures at the intake session. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

Qualifications: I have been a Licensed Professional Counselor since 2003. I have a Master of Arts degree in Counseling from Amberton University. I also provide Supervision for Counseling Interns working toward their state licensure.

Experience: In my clinical experience I have counseled multiple individual adults and adolescents, groups, and couples. I have worked in community counseling centers, a mental health hospital, in the field of addiction recovery and now in a private practice setting.

Nature of Counseling: My theory of counseling encompasses all aspects of my clients' lives including their biology, their social systems such as family and friends, their culture, their emotions, thoughts, and behaviors, and their spiritual and/or religious lives. As a therapist, I take an integral approach, which simply means that I look at all aspects of the individual from a developmental perspective without discrimination or prejudice. Our therapy together will focus on building our therapeutic relationship as we work together on the specific issues you bring to counseling. We may choose together to try any number of behavioral, cognitive, educational, or relationship building techniques that will help you on your personal journey of change and self-discovery. I rely heavily on systems theory that focuses more on the dynamic relationships that clients are in with their partner/spouse, family of origin, friends, co-workers, etc. Overall, our time together will be about your personal journey toward health and fulfillment with me as a fellow traveler on your journey of self-discovery and healing.

Conditions of Counseling

Counseling Relationship: Unless you prefer otherwise, I will call you by your first name. Please call me Randy**.** During the time you and I work together, we usually will meet weekly for approximately 50-minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation or gender identity. If significant differences, such as in culture or belief system, exist between us, I will work to understand and be sensitive to those differences.

Effects of Counseling: At any time, you may initiate with me a discussion of possible positive or negative effects of entering or not entering into, continuing, or discontinuing counseling. I expect you to benefit from counseling. However, I cannot guarantee any specific results. Counseling is a personal exploration that may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. You may feel troubled, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. In addition, counseling can, at times, result in long lasting effects. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, I ask that you participate in a termination session. You also have the right to refuse or to discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors: 512-834-6658**.**

Appointments, Cancellation, and Crises: Psychotherapy sessions are 50 minutes and billed at $135 per session. Session fees are payable at the time of service unless alternative arrangements have been made. In the event that you are unable to keep an appointment, please notify me at least 24 hours in advance, whenever possible. Likewise, if you intend to discontinue counseling, please inform me immediately so that I may offer your scheduled time to another client. A "no show" fee of $100 will be assessed for non-cancelled and late cancelled appointments. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

If you have a life-threatening emergency, please call 9-1-1 or go to your local hospital emergency room. If you or I believe you need a greater level of service than I can provide, we will arrange referral to a resource that is better able to meet your needs.

FEE SCHEDULE:	Regular Office Visits (50 minutes)	$135
	Missed appointments without 24hr notice (other than for illness/emergency)	$100

PAYMENT/INSURANCE FILING: Although I am not a participating provider in your managed care plan, I will file on your out-of-network benefits if your plan includes them or I will provide you with a monthly statement upon your request that you may submit to your insurance to obtain out-of-network reimbursement. Insurance companies sometimes require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. I will be glad to discuss your diagnosis and the significance of filing for treatment of the diagnosis.

CASH and CHECK payments are *preferred* and *appreciated*. HSA and FSA cards are accepted. And Bank Debit/Credit Cards (VISA, Master Card, Discover) are accepted if necessary.

Records: I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally I keep very brief records noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained using a secure, HIPPA compliant, electronic service. Files are closed once the counseling relationship ends. As required by law, I will maintain records for five years after the counseling relationship ends.

Confidentiality: Law generally protects the confidentiality of all communications between a client and a therapist. Without your written permission, I cannot and will not tell anyone else what you have discussed or even that you are in therapy. In most situations, I can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. With the exception of certain specific situations described below, you have the right to confidentiality of your therapy. You, on the other hand, may request that information be shared with whomever you choose, and you may revoke that permission in writing at any time.

Discussions between you and me, even the fact that you are in counseling with me, are confidential. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first. Further information about confidentiality is addressed in the HIPAA notice form which is available via a link at the "Forms" tab on my website, martinlpc.com, or, at your request, a hard copy from me

There are several exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:
1. *If there is good reason to believe you are threatening serious bodily harm to yourself or others* – If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions that may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client or to contact family members, the emergency contact, or others who can provide protection.
2. *If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly, or disabled persons* – In such a situation, I am required by law to file a report with the appropriate state agency.
3. *In response to a court order or where otherwise required by law*
4. *To the extent necessary for emergency medical care to be rendered*

Finally, there are times when I find it beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your name and unique identifying characteristics will never be disclosed. The consultant is also legally bound to keep the information confidential.
You are not required to waive your right to confidentiality at any time. In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact your emergency contact in addition to medical and/or law enforcement personnel.

Contacting Me: I am often not immediately available by telephone. I am not always in the office during normal business hours, and I do not answer the phone when I am with a client. If you need to reach me between sessions, or in an emergency, you have the right to a timely response. You may leave a message on my confidential voicemail at any time, and your call will be returned as soon as possible. I will make every attempt to inform you in advance of any planned absences and to provide you with a name and phone number of the therapist covering the practice.

Taping: I do not consent to be video or audio recorded during our sessions or at any other time. If, for some reason, you would like documentation of what happened during one or more sessions, I will provide you with a copy of my notes.

Referrals: I recognize that the services I offer are not always appropriate or sufficient to fully meet the issues client's present. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Other Rights: If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such criticism will be taken seriously, with care, and with respect. You may also request that I refer you to another therapist, and you are free to end therapy at any time.

You have the right to considerate, safe, and respectful care without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.
You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationship with clients or with former clients.

Consent to Therapy:

Please initial the following items:

_______ I understand that Randy Martin does not provide 24-hour crisis counseling. Should I experience an emergency requiring immediate mental health attention, I will immediately call 9-1-1 or go to the nearest emergency room for assistance.

_______ I understand that Randy Martin does not consent to be video or audio recorded at any time.

_______ I understand and agree to pay in full for any appointments I fail to attend or cancel without 24-hours notice.

_______ I understand that Randy Martin is not an expert witness, nor does he provide testimonial services.

_______ I understand that should I cause Randy Martin to be subpoenaed as a factual case witness or involve him in court-related processes, I will be required to pay a retainer fee of $1000 as well as a charge of $250 every hour he is involved in the case preparation, phone calls, travel, and witness time, etc.

_______ I understand that if I do issue Randy Martin a subpoena, my subpoena will be directly turned over to his attorney and a bill will be rendered to me for immediate retainer fee payment.

Confirmation of Receipt of Privacy Notice and Informed Consent
By your signature below, you are indicating 1) that you have received a copy of the *HIPAA Notice of Privacy Practices* and a copy of the *Agreement*; 2) that you voluntarily agree to receive mental health assessment and medical health care, treatment, or services, and that you authorize Randy Martin to provide such services as considered necessary and advisable; 3) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such services received through Randy Martin; 4) that you have read and understand this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you.

Release for Liability and Hold Harmless Provisions: By signing this document, you are releasing Randy Martin and holding him harmless from any personal liability that arises from departure from your right of confidentiality.

By my signature, I verify the accuracy of the *Notice of Privacy Practices* and of the *Agreement* and acknowledge my commitment to conform to their specifications.

____ ______________________________
Client Signature Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

____ ______________________________
Client Date

I authorize the payment of medical benefits to the provider of services.

____ ______________________________
Client Date

I authorize this provider to contact and release medical, mental health and substance abuse information regarding my treatment to my Primary Care Physician and Psychiatrist.

____ ______________________________
Primary Care Physician - Phone Psychiatrist - Phone

____ ______________________________
Signature – Client Date