Professional Informed Consent

(Adapted from [www.centerforethicapractice.org](http://www.centerforethicapractice.org) and [www.therapistprivatepractice.wordpress.com](http://www.therapistprivatepractice.wordpress.com))

**Welcome to Prosper Counseling.** This document contains important information about my professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your protected health information for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is important that you understand them. When you sign this document, it will represent an agreement between us. We can discuss any questions you have before you sign them or at any time in the future.

Top of Form

**Counselor Qualifications:** Marcey Mettica is a Licensed Professional Counselor Supervisor in the state of Texas and a Registered Play Therapist through the Association for Play Therapy, requiring additional training and experience working with children. Marcey is in a PhD program pursuing her Doctoral degree in Family Studies. Marcey has extensive experience working with children, adolescents, families, and adults in a variety of settings including agency, hospital, legal, church, and private practice facilities. Marcey believes counseling provides an opportunity for growth and self-discovery in a safe and supportive environment and therapeutic relationship.

**Client Rights**: Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your counselor, I have corresponding responsibilities to you as well. As the client, you are in complete control and may end your counseling relationship at any time. You also have the right to refuse or discuss modification of any of your counselor’s counseling techniques or suggestions that you believe might be harmful. Should you and/or your counselor believe that a referral is needed; your counselor will provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives. Marcey Mettica’s counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time or for any reason you are dissatisfied with your counselor’s services, please let your counselor know so that existing issues can be worked through. If your concerns still persist, you may report your complaints to the Texas Board of Examiners of Licensed Professional Counselors.

**Benefits/Risks of Counseling:** Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. Counseling is a personal process which can bring unpleasant memories or emotions to the surface. Progress may happen slowly at times. Counseling requires a very active effort on your part. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discounting counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling may help you (or your child) develop coping skills, make behavioral changes, reduce symptoms, and improve the quality of your life. Together you and your counselor will work to achieve the best possible results for you.

**Appointments:** During the time we work together, we (or your child) will initially meet weekly for approximately 45-50 minutes per session. As therapy continues, we may have sessions more or less frequent as needed. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours’ notice. ***If you miss a session without cancelling, or cancel with less than 24 hour notice, you may be required to pay for the session,*** unless we both agree that you were unable to attend due to circumstances beyond your control (e.g. sick child, weather, family emergency). ***If not, you will be responsible for a cancellation fee of $50.00***. If you arrive late for your appointment, it will still need to end on time as other clients are likely scheduled after you.

**Emergency Situation:** You understand that Marcey Mettica does not provide a 24-hour crisis counseling service. All services are provided by appointment only. Should you experience an emergency necessitating immediate mental health attention, call 9-1-1 or go to the nearest emergency room for assistance. Should you need to contact Marcey between sessions, you may leave a voicemail at (214) 914-1018.

**Professional Fees:** In return for a **fee of $120.00 per session**, Marcey Mettica agrees to provide counseling services for you or your child. The fee for each session will be due at the commencement of each session. ***The rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, interactions with insurance providers, phone calls over 15 minutes, etc. will be billed at $120.00 per hour in 15-minute increments.*** The rate for group services is $80 per session. You will be billed according to the standard mileage rate for any service that requires travel. All returned checks will incur a $25.00 return-check fee. In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance*.* ***If no notification, or less than 2-hour notification, is made a regular session fee will be billed to you.* *If less than 24 hour notice is provided a $50 charge will be assessed.*** Emergency cancellations beyond your control will not be billed for. If you do, at any time, intend to discontinue counseling, please inform your counselor as soon as possible so that other clients can be serviced.

**Records**: Records are kept of all of your and your counselor’s communications, including contact via phone and email, and are maintained in a HIPAA compliant system. Records are the property of Marcey Mettica of Prosper Counseling and are stored in MHPOffice.com which provides HIPPA compliant security features including passwords, SSL encryption of notes, FIPS140-2 encryption on web browser, and audited restricted access to servers. All client records are backed up daily. Client records are disposed of seven years after the file is closed. Files of clients who are minors, or who were minors, when they began treatment will be disposed of seven years beyond when the minor reaches 18 years of age. In the case that Marcey Mettica is unable to serve as custodian of records (i.e. upon death or other incapacitation) Gillian de La Sayette, LPC will assume the role and can be reached at 214-727-2263.

**Divorced Parents**: If a divorce or a separation of parents has occurred, a current copy of the relevant court documents, including any temporary orders or a final divorce decree, is required to begin services. If joint custody exists, the parent not bringing the child may also be invited to participate in the counseling process. In most custodial arrangements, both parents have the right to contact the therapist and inquire regarding their child’s treatment progress, unless otherwise indicated by the courts. If your conservatorship/guardianship is established by a divorce decree or custody document, you are required to furnish a photocopy of the cause page, the page specifying conservators, the page indicating the right to consent for psychological services, and the signature page from the decree or document before clinical services can begin.

**Confidentiality** **and Limits of Confidentiality**: Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be asked to sign a consent form before information will be released; however, there are some limits to confidentiality you need to be aware of. Your counselor may consult with another professional counselor in order to give you the best service, but no identifying information will be released.

**Use of Technology:** If you choose to use Email, Skype, telephone, text, or other technology to communicate with your counselor, your counselor cannot guarantee your confidentiality. To receive information via email, a *Consent Form for Receiving Emailed Receipts from Prosper Counseling/First Street Counseling & Consulting, PLLC* must be signed. Any electronic transmissions of information by you are considered part of the clinical record and retained in your file. Any emails or texts received from you and any responses sent to you will become part of your or your child’s therapy record.

**Group Therapy:** If you choose to participate in group therapy, your counselor will take every precaution to safeguard your information but cannot guarantee group members’ confidentiality. The nature of group therapy makes it difficult to guarantee confidentiality; however, your counselor will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your counselor also has the right to remove any group member should she discover that member has violated the group’s confidentiality rule.

**Social Media:** Although sessions may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not ask Marcey Mettica to relate to you in any way other than the professional context of your counseling sessions. Marcey Mettica does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy for both the therapist and the client. Because they can blur the boundaries of the professional relationship, they are not permitted. You will best be served if sessions concentrate exclusively on you (adult counseling situations) or your child’s concerns (parent consultations for child or adolescent counseling). The counseling relationship is limited to the counseling sessions you arrange with Marcey Mettica.

**Filming:** Sessions with clients are routinely filmed for security and protection of the client and counselor. Recordings are used only for security purposes and are not reviewed or downloaded to a transportable medium, unless a situation arises during the counseling session necessitating the need. Please inform your counselor if you (or your child) are uncomfortable with the sessions being filmed.

**Public Encounters:** To further protect your confidentiality, if your counselor sees you in public, she will only acknowledge you if you approach her first. In the case of child, marriage or family counseling, your counselor will keep confidential anything you disclose to your counselor without your family member's knowledge. However, your counselor encourages open communication between family members, and your counselor reserves the right to terminate the counseling relationship if your counselor judges the secret to be detrimental to the therapeutic progress.

**Limits to Confidentiality:** Counselors are required by law to release information if a client poses a risk to themselves or others, in cases of abuse to children, disabled or the elderly, or if mandated by a court order. In such a case, your counselor will limit the release to only what is necessary by law. Situations that require your counselor to disclose information without your consent may include:

* You are a danger to yourself or someone else.
* You disclose sexual contact with a mental health professional with which you had a professional therapeutic relationship.
* You disclose that you are infected with a potentially life-threatening illness that could be transmitted to a specific uninformed person.
* Marcey Mettica is ordered by a court to disclose information, including, but not limited to: testifying in a child custody or visitation case involving you, testifying in a lawsuit in which your mental health is an issue, you have been charged with a crime, or you bring a negligence suit against Marcey Mettica or Marcey Mettica is otherwise required by law to disclose information.
* There is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.
* Comments made about Marcey Mettica or her services on public mediums (i.e. internet, radio, newspapers, etc.) constitute an infringement upon your confidentiality. In the event you publically remark about Marcey Mettica, Prosper Counseling, or First Street Counseling & Consulting, PLLC, you consent to allow Marcey Mettica to use confidential information if necessary to respond.

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**Top of Form**

**Bottom of Form**

**Legal Proceedings:** Marcey Mettica does not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause Marcey Mettica to be used in this way. Should you or your attorney subpoena Marcey Mettica as a factual case witness or involve her in court-related proceedings, you agree to pay Prosper Counseling/First Street Counseling & Consulting, PLLC $240.00 for every hour of time involved including case preparation, phone calls with attorneys, travel, and witness time. You further agree to pay a retainer fee of $1,000.00 at the time a subpoena is served or you or your attorney involve her in court-related proceedings, which will be applied toward these charges. A bill will be rendered to you for immediate payment when a subpoena is issued or your attorney involves her in court-related proceedings. Please let Marcey Mettica know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motives.

Should you or your legal representative direct and consent in writing to Marcey Mettica to release a copy of your records, please be aware that both a record preparation fee ($.35/page, minimum of $50.00) will be incurred and a “*Release of Records”* form must be signed. A copy of the record will be provided within 15 business days of the receipt of both. In the case of shared custody of a minor, multiple individuals may have rights to the client’s record. If one guardian formally requests a copy of the records, additional copies may be provided to the other guardians who are actively participating in services. If records are requested or subpoenaed, this does not indicate an automatic release of records and Marcey Mettica may choose to seek a court order squashing the subpoena or providing protection should disclosure be deemed not in the client’s best interest.

**CLIENT CONSENT AND AUTHORIZATION**

By your signature below, you are indicating that you have read and understood the contents of this document, and that any questions you had about this document were answered to your satisfaction. You also attest that you were furnished a copy of this document upon your request, acknowledge your commitment to comply with all of its terms and requirements, issue consent for Marcey Mettica, MS, LPC-S, RPT to work with you and/or your child, and acknowledge understanding and agreement to your counselor’s fee schedule. You understand this authorization can be revoked at any time through your written request. Unless otherwise indicated, it will remain in effect until you revoke authorization in writing.

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Client or Guardian’s Signature (if guardian please state relationship) Date

**Health Provider’s Statement**

I have inquired to insure that the patient understood the informed consent and limits on confidentiality.

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**HIPAA Notice of Privacy Practices**

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

## Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

**Treatment:** We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, calling you by name in the waiting room when the therapist is ready to see you and other clients or therapists may be present. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization and opportunity to object unless required by law.

**You may revoke this authorization at any time**, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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# Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

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Client signature (parent or guardian if minor patient) Date

Who Is Financially Responsible For This Account?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_Zip

E-mail

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone

***Understanding and Authorization of Financial Responsibility:***

This office operates as a private pay out-of-network provider. Your counselor can provide you all necessary paperwork for you to file for your own insurance reimbursement. Generally speaking, most insurance companies will pay a percentage of each session after you meet your deductible. Typically, insurance companies reimburse clients at a 80/20, 70/30, or 60/40 where they reimburse for the majority of the costs based on the individual plan you carry. Many clients have utilized their FLEX spending accounts to pay for services. Your signature below indicates your understanding that it is your responsibility to inquire if your insurance policy will cover your counseling services.

I give Marcey Mettica, MS, LPC-S, RPT, the right to seek the services of a bill-collecting agency in efforts to collect fees that I have not paid to her for services rendered and/or for cancelled or missed appointments.

**Signature**

***Authorization and Release of Information for Insurance Purposes:***

There are many reasons mental health professionals do not join insurance panels. The most important being that the in-network filing process usually requires a significant breach of client confidentiality. For example, to meet the requirements for in-network reimbursement, the counselor must submit an official client diagnosis and an ongoing progress report, treatment plan, etc.  Such information requires that the therapist divulge a good deal of personal information about the client, which then becomes part of his or her permanent medical record which can be accessed by others. This is why Marcey Mettica, MS, LPC-S, RPT has chosen not to be on insurance panels. There is no way to insure client confidentiality when a client files insurance claims.

***Should you elect to file an insurance claim in an effort to seek reimbursement,*** your signature below serves as authorization to release any information including the diagnosis and records of any therapeutic treatment rendered to you or to your child during the period of such care to third party payers and/or other health practitioners.

Signature

**Consent Form for Receiving Emailed Receipts**

**from Prosper Counseling or First Street Counseling & Consulting, PLLC**

Secure electronic messaging is always preferred to insecure email for more sensitive protected health information (PHI), but under specific circumstances, insecure email communication containing protected health information may take place between Prosper Counseling or First Street Counseling & Consulting, PLLC and a client. This email communication may be used if the client agrees on this communication method and this form is completed and signed by the client or the client’s personal representative (parent for a child).

A copy of this form will be filed in the client’s file and a hard copy of this form will be provided to the client upon request. This consent is limited to receiving accounting, scheduling, and other miscellaneous email communications from [prospercounseling@gmail.com](mailto:prospercounseling@gmail.com) or [marceymettica@yahoo.com](mailto:marceymettica@yahoo.com) to the email address listed below.

**Client Awareness**:

Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is an always an alternative that is available to you. By completing this form, you understand and are willing to accept the risks involved with insecure email communication of your protected health information.

**Withdrawal of Agreement for Email Communication:**

Should you no longer wish to communicate via email a written request to withdraw must be delivered in person or sent by U.S. mail to Prosper Counseling at 3067 Falcon Road, Prosper, TX 75078. A copy of the withdrawal form will be filed in your file.

Client’s Name (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Authorized Email Address (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Marcey Mettica, MS, LPC-S, RPT of Prosper Counseling / First Street Counseling & Consulting, PLLC to charge my credit card according to our agreed upon rates for services outlined in the “Professional Disclosure Statement” provided to me. I understand these charges include but are not limited to sessions cancelled with less than 24 hour notice, sessions not attended, and phone consultations exceeding 10 minutes. I understand that I will be provided a copy of my receipt upon request and/or at my next in person session.

VISA / Mastercard / American Express / Discover

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Authorization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_