LENA POPE | Counseling Services

☐ Counseling

☐ SATS

Client Information Sheet

Today's Date: _____

CLIENT INFORMATION

Client Name: _____ **Client DOB:** _____

Sex: _____ **Marital Status:** _____ **Ethnicity:** _____

Last Grade Completed: _____ **Employer/School:** _____

Client's Soc. Sec. #: _____ **Parent/Guardian of Client:** _____

Insurance: _____ **Is anyone in your family in the military or a veteran?** Yes No

☐ Veteran ☐ Active Duty ☐ Texas National Guard ☐ Reserve Force

HOME ADDRESS

_____
Street Apt #

_____
City State Zip Code

Email Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone Company: _____

May we contact you by email/text? Yes No

ANNUAL HOUSEHOLD INCOME

☐ Less than 20,750 ☐ 20,750 – 34,599 ☐ 34,600 – 55,349 ☐ 55,350 +

PLEASE LIST ALL INDIVIDUALS LIVING IN THE HOME:

Full Name	DOB	Sex	Ethnicity	Marital Status	Relationship To Client	Last Grade Completed	Employer/School

What is your goal for counseling? _____

_____

_____

LENA POPE | Counseling Services

EMERGENCY CONTACTS

In the case of an emergency or if we become concerned about your safety or the safety of those around you, we may need to contact someone close to you (relative, spouse or close friend). Please write down the name and contact information of your chosen emergency contact:

Name:_____ Address:_____

Phone:_____ Relationship:_____

My signature affirms that I have read or heard the information above and that it was presented to me in clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to counseling for myself and/or the child named below.

_____ _____

Adult Client's/Consenting Adult's Name Adult Client/Consenting Adult's Signature

_____

Minor Client's Name

_____

Today's Date

LENA POPE | Counseling Services

Consent to Release/Obtain Information

Full Name of Client: _____ Date of Birth: _____

Name: _____
(i.e. Full name of individual(s), "All past/current/future treating providers", etc.)

Entity: _____ **Phone:** _____
(i.e. Physician's Office, Other Mental/Behavioral Health Provider, DFPS, OCOK, Probation, Attorney's Office, etc.)

Address: _____
(Street) (City) (State) (Zip Code)

I, _____, _____ **authorize Lena Pope Home, Inc. to**
Name (First & Last) Date of Birth

( ) Release information ( ) Obtain information

Regarding treatment for: ( ) Myself ( ) My child.

This information may be released/obtained: ( ) Verbally ( ) In writing

The purpose of the disclosure authorized herein of client information is (purpose as specific as possible):

( ) S.S.I.	( ) Treatment purposes	( ) Coordination of Care (letter)
( ) Disability	( ) Transfer to new services	( ) Educational Records
( ) Insurance documentation	( ) Personal documentation	( ) Other _____

Information to be Released/Obtained:

( ) Diagnosis	( ) Progress Notes	( ) Closure Summary
( ) Clinical Assessment	( ) Psychosocial Assessment	( ) Educational Records
( ) Psychiatric Records	( ) Substance Use Treatment	( ) Treatment Plan
( ) Summary of Treatment Records and Contact Dates		( ) Recommendations
( ) **Entire Record**	( ) Other _____	

I understand that my records are protected under Federal regulations governing Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in Federal and State regulations. I understand that the information authorized for disclosure pursuant to this Consent will include a notice of prohibition of re-disclosure. I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by State regulations. I understand that I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that I may revoke this Consent at any time by providing written notification of my revocation to Lena Pope except to the extent that the request has already been executed. I understand that this Consent will automatically expire 1 year from the date signed. I acknowledge my right to receive a copy of this Consent upon completion.

( ) I hereby refuse to give authorization for any release of information

Signature of client/representative: _____ Date: _____

If representative, describe authority to act for the individual: _____

Witness: _____ Date: _____

LENA POPE | Counseling Services

Receipt of Notice of Privacy Practices

I _____ acknowledge receipt of the Notice of Privacy Practices of Lena Pope.

I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations as described in the Notice of Privacy Practices.

This means that information about my health will be used by the staff of Lena Pope or disclosed to other people or organizations whenever needed to:

- Provide treatment to me or arrange for treatment by another health care provider.
- Arrange for payment for services provided to me.
- Operate the business of Lena Pope.
- Enable other health care organizations that provide treatment to me or pay for services provided to me to review the quality and appropriateness of care I receive and conduct other health care operations.

I wish to receive a copy of the Notice of Privacy Practices electronically. These should be sent to:

_____.

Signature: _____ Date: _____

LENA POPE | Counseling Services

General Information and Consent for Treatment of Self or of Minor Child

It is our belief that we can establish a better relationship and serve you more effectively if you are familiar with the procedures of this program. We believe in continuous improvement in the quality of services that are provided at Lena Pope and may ask you to assist us by completing a satisfaction survey. These are available at the front desk. Please be advised that a staff person may be calling you after counseling services has ended for follow-up and aftercare.

APPOINTMENTS AND SCHEDULING

Based on the need and the assigned program, clients are seen in the office, home, or community. Lena Pope acknowledges the value of Emotional Security Animals (ESAs), however ESAs are not allowed in any Lena Pope offices. Individual appointments are generally fifty-minute sessions. Groups are typically 90 minutes. To contact someone about rescheduling or cancelling an appointment call **(817) 255-2652**. All telephone calls will be returned as soon as possible. **Arriving more than 15 minutes late for a session may result in loss of your appointment.**

We ask that you call our office at least 24 hours in advance if you need to cancel or reschedule. There is a $25 fee for missed appointments, as well as appointments cancelled with less than 24 hours' notice. Individuals who miss two appointments without prior notification during treatment are subject to removal from the appointment calendar.

In case of bad weather, your therapist will call if the office closes and your appointment needs to be rescheduled.

If you have a medical emergency, call 911. If you feel a non-medical emergency exists and it is after office hours, please call your county's Hotline Number listed: Tarrant County 1-800-866-2465 or text 817-335-3022 and for Hood / Parker Crisis Hotline 1-800-772-5987

CONFIDENTIALITY

Lena Pope staff take every reasonable measure to ensure your confidentiality. However, confidentiality and privileged communication are limited under Texas law and professional codes of ethics. Lena Pope staff are required to report any suspicions or evidence of child abuse; abuse of those who are elderly or disabled; a person's intent to take harmful, dangerous, or criminal actions against another human being or against him/herself; and sexual exploitation by a mental health provider.

PHILOSOPHY

The practice of counseling requires mutual understanding, respect, and confidence. We look forward to providing you services with the highest professional standards of counseling. Lena Pope uses evidence-based practices and programs. Depending on the program that you are enrolled in, services can include screenings, assessments, individual, family, couples, group counseling, school or community-based groups, and in-home counseling. Your therapist will discuss his or her personal method of treatment and will help you decide on goals for your treatment.

Your therapist will help you decide if including family members or significant others in your treatment will assist you in reaching your goals. It is also important to understand that participation in counseling can lead to individual changes that could affect your relationships and interactions with others in both positive and negative ways. If you wish, your therapist can discuss alternate forms of treatment for your concerns.

Adult Client/Consenting Adult Name | Adult Client/Consenting Adult Signature | Date

LENA POPE | Counseling Services

TREATMENT OF MINORS

Parents and legal guardians have the right to request information concerning a minor's evaluation and treatment. We will protect the rights and confidentiality of all minors and therapists use their discretion in communicating information disclosed by minors in private. Risky behaviors such as drug use, running away or self-harm will be reported to parents/legal guardians. Your therapist will further discuss the issue of confidentiality of minors prior to beginning services.

Please complete this section only if a child will be involved in counseling sessions with Lena Pope.

[redacted]

Child's Name | Date of Birth | Child Signature

[redacted] [redacted]

Mother's Name | Father's Name

Child's Name | Date of Birth | Child Signature

Mother's Name | Father's Name

Child's Name | Date of Birth | Child Signature

Mother's Name | Father's Name

I attest that I have the right to consent for treatment of the child named above and I have provided documentation of this, as needed.

Name of Consenting Adult | Relationship to Child (ren)

[redacted]

Signature of Consenting Adult | Date

LENA POPE | Counseling Services

Telemental Health Informed Consent for Treatment of Self or of Minor Child

As a client or patient receiving mental services through telemental health technologies, I understand:

1. Telemental health is the delivery of mental health services using interactive technologies (use of audio, video or other electronic communications) between a therapist and a client who are not in the same physical location.
2. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of mental health information and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

3. This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.
4. Regardless of the sophistication of today's technology, some information a therapist would ordinarily utilize in in-person sessions may not be available in telemental health sessions. I understand that such missing information could, in some situations, make it more difficult for a therapist to understand my problems and to help me.
5. Telemental health services may not be covered by insurance. ***During the COVID-19 disruption, most insurance companies have agreed to pay for telemental health as they would for in-person sessions. Should you have questions about your specific insurance company's policy, please reach out to them directly.***

Risks of Technology:

6. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
7. I understand that telemental health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet known.
8. Among the risks that are presently known is the possibilities that the technology will fail before or during the sessions, that the transmitted information in any form will be unclear or inadequate for proper use in the sessions, and/or that the information will be intercepted by an unauthorized person or persons.
9. In rare instances, security protocols could fail, causing a breach of privacy of personal health information.
10. I understand that if I enter private information on a public access or shared computer or

network, it is possible that it can be accessed by other people. I should ensure the equipment I am using is private.

11. "Auto-remember" of usernames and passwords should not be used when using telemental health services.

Technology Requirements:

12. I understand that I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information:

13. The exchange of information will not be physical, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
14. During my telemental health sessions, details of my medical history and personal mental health information may be discussed with myself or other mental health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

15. If a need for direct, in-person services arises, it is my responsibility to contact my therapist's office for an in-person appointment, or my primary care physician if my therapist is unavailable. I understand that an opening may not be immediately available in either office.

Discontinuing Care:

16. I understand that at any time, the sessions can be discontinued either by me or by my designee or by my mental health care provider.
17. I further understand that I do not have to answer any question that I feel is inappropriate or that I do not wish persons present to hear; and that any refusal to participate in the sessions or use of technology will not affect my continued treatment; and that no action will be taken against me based upon such refusal to participate.
18. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. If that occurs, my telemental health-based treatment might be less successful than it otherwise would be, or it could fail entirely.
19. I may decline any telemental health services at any time without jeopardizing my access to future care, services, and benefits.

Modification Plan:

20. My therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of telemental health, and modify our plan as needed.

Emergency Protocol:

21. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
22. In emergency situations: _____

Disruption of Service:

23. Should service be disrupted: my therapist will immediately call me back. If I am not able to answer, my therapist will use other communication means to ensure you are safe (i.e. text, email.) and services are delivered effectively.
24. For other communication: _____

Therapist Communication:

25. My therapist may utilize alternative means of communication in the following circumstances: disruption in cell service, you not answering phone calls, disruption in video/audio equipment or internet service
26. My therapist will respond to communications and routine messages within 24 HOURS.

Client Communication:

27. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
28. I will take the following precautions to ensure that my communications are directed only to my therapist or other designated individuals: _____

Records and Web Maintenance:

29. My therapist will maintain electronic records in accordance with relevant laws and statutes. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long the archival storage of records are maintained.
30. My communication exchanged with my therapist will be stored in the following manner: _____

Laws & Standards:

31. The laws and professional standards that apply to in-person mental health services also apply to telemental health. These can be found at https://www.bhec.texas.gov/statues-and-rules/index.html

Mobile Application:

32. My private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application" (abbreviated as "app").
33. I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My mental health care provider has explained the alternative to my satisfaction.

Equipment:

34. I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I understand the risk that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

35. I understand that I will be informed of the identities of all parties present during the sessions or who have access to my personal mental health information and of the purpose for such individuals to have such access as referenced in the Receipt of Privacy Practices I was provided.

Telemental Health Process:

36. My therapist has explained how the telemental health sessions are performed and how they will be used for my treatment. My therapist also explained how the sessions will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.
37. There is potential for misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically. My therapist will address this with me individually.
38. My therapist will verify my identity if using audio-only services. An individualized ID number will be given to me, and my therapist will ask for me to give him/her that number to verify my identity at the beginning of each session.

Additional Services:

39. I understand that it is my duty to inform my therapist of electronic interactions regarding my care that I may have with other mental health care providers.

Electronic Presence:

40. In brief, I understand that my therapist will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my therapist.

Release of Information:

41. I authorize the release of any information pertaining to me determined by my therapist, my other health care practitioners or by my insurance carrier to be relevant to the sessions or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information to my insurance company.

Limits of Confidentiality:

42. I also understand that, under the law, and regardless of what form of communication I use in working with my therapist, my therapist may be required to report to law enforcement authorities information suggesting that I have engaged in behaviors that endanger myself or others.

Alternatives:

43. The alternatives to the telemental health sessions have been explained to me, including their risks and benefits, as well as the risks and benefits of going without treatment. I understand that I can still pursue in-person sessions. I understand that the telemental health sessions do not necessarily eliminate my need to see a therapist in person, and I have received no guarantee as to the telemental health sessions' effectiveness.

Records:

44. I understand that my telemental health sessions may be recorded and stored electronically as part of my medical records. I understand that sessions and disclosures will be held in confidence subject to state and/or federal law.
45. I understand that I am ordinarily guaranteed access to my records and that copies of my records are available to me on my written request.
46. I also understand, however, that if my therapist, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Contact Information:

47. I have received a copy of my therapist's contact information, including his or her name, telephone number, voice mail number, business address, mailing address, and e-mail address.

Emergency Care:

48. I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telemental health session. Instead, I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.
49. I am aware that my therapist may contact the proper authorities and/or my designated,

local contact person in case of an emergency.

50. These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

MHMR iCARE Hotline **Name**
(817) 335-3022 **Telephone Number**

Name
Telephone Number

Name
Telephone Number

Release of Liability:

51. I unconditionally release and discharge Lena Pope Home, Inc, its affiliates, agents, and employees any liability in connection with my participation in the remote sessions.

Final Agreement:

52. I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.
53. With this knowledge, I voluntarily consent to participate in the telemental health sessions, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

My signature affirms that I have read or heard the information above and that it was presented to me in clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to counseling for myself and/or the child named below.

Adult Client's/Consenting Adult's Name Adult Client/Consenting Adult's Signature

Minor Client's Name

Today's Date

LENA POPE | Counseling Services

Client Bill of Rights
(Ref. DSHS §448.701)

Each Lena Pope program shall respect and protect client's rights. As a client of Lena Pope, you have a right to the following:

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation.
3. You have the right to be treated with dignity and respect.
4. You have the right to receive services in a culturally responsive to your individual and/or family's needs.
5. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
6. You have the right to be told about the program's rules and regulations before participating in treatment, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusions.
7. You have the right to be told before participating in treatment:
    a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits, and side effects of all proposed treatment;
    d. the probable health and mental health consequences of refusing treatment; and
    e. other treatments that are available and which ones, if any might be appropriate for you;
    f. the expected length of stay.
8. You have the right to refuse or accept treatment after receiving this explanation.
9. If you agree to treatment, you have the right to change your mind at any time (unless specifically restricted by law).
10. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
11. You have the right to meet with staff to review and update the plan on a regular basis.
12. You have the right to refuse to take part in research without affecting your regular care.
13. You have the right not to be restrained unless you are a danger to yourself or others.
14. You have the right to have information about you kept private and to be told about times when the information can be released without your permission.
15. You have the right to be told in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
16. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
17. You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
18. You have the right to complain directly to the Texas Department of State Health Services at any reasonable time.
19. You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Department of State Health Services.
20. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of being admitted.

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature Date

By signing, I acknowledge that I have been explained the Bill of Rights as they are outlined here, and that I may request a written copy of the Bill of Rights.

Ensure that the client (and consenter, if applicable) receives a copy of this document AND that a copy is placed in client's record.
Revised 07/15/13, 06/22/14, 8/1/14

LENA POPE | Counseling Services

Grievance Procedure

I _____ acknowledge that within 24 hours of beginning services with Lena Pope, I was informed that I have the right to file a complaint or grievance about any problem that I may wish to have addressed.

I have received instruction in where to get complaint or grievance forms. I also understand how to file a complaint and how my complaint will be resolved.

I understand no one can punish, threaten, or discriminate against me for using or helping someone else file a complaint or grievance.

I understand that if I am not satisfied with any decision regarding my complaint, that I have the right to appeal the decision to the next highest level and to the Executive Director of Lena Pope.

The following is a list of steps of the grievance process:

a. Any client may request a Grievance Form from any Counseling Services staff member in-person or by calling (817) 255-2652.
b. Any client may request and will be provided writing materials, postage, access to a telephone for the purpose of filing, and/or assistance in completing the form from a Counseling Services staff member.
c. Any client may submit a completed and signed form to the Counseling Services Supervisor or Director. A copy of the form will be provided to the Executive Director and Director of Human Resources. If there is an issue that requires more immediate attention, additional copies of the form will be distributed to the appropriate individuals as soon as possible.
d. The Counseling Services Supervisor or Director will evaluate the grievance thoroughly and objectively, obtain additional information as needed, and respond to the client with the proposed resolution(s) within seven (7) business days.
e. The Counseling Services Supervisor or Director will document the grievance process and a copy of the form, resolution(s), and outcome(s) will be sent to the Executive Offices.
f. Documentation of all grievances will be maintained in a central file in the Counseling Services Department.
g. Any client may file the grievance directly with the Texas Behavioral Health Executive Council. (Texas Administrative Code §884.31(b))

NOTICE TO CLIENTS

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Texas Behavioral Health Executive Council
333 Guadalupe St., Tower 3, Room 900, Austin, Texas 78701
1-800-821-3205 toll-free

By signing my name, I acknowledge that I have been explained the Grievance Procedure as they are outlined above, and that I understand how to file a complaint or grievance.

_____ _____
Client's Signature Date

_____ _____
Parent's Signature Date

_____ _____
Witness Date

Client and Consenter may receive a signed copy of this document.

LENA POPE | Counseling Services

Client Name: _____

CONSENT TO BILL INSURANCE AND FINANCIAL ATTESTATION FORM

FEES

If you have eligible insurance coverage, we will submit claims on your behalf. **Those who have Medicaid coverage are required to present a Medicaid card at each visit.** If you do not have insurance, financial assistance may be available and is determined based on family size and income level (proof of income is required). There is a $25 charge applied for returned checks.
All fees/co-pays are due at the time services are provided.

I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules and state laws for protection of the privacy of your health information, but those rules and laws do not apply to all organizations.

I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time.

I am the person who is the subject of the health records that will be used or disclosed, or I have the legal right to consent for that person. I agree to the use and disclosure of health information as described in this consent.

I understand that the services or items that I have requested to be provided to me may not be considered by my insurance as being reasonable and medically necessary for my care. I understand that the insurance company determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

I understand if Lena Pope provides services that are not covered by insurance I will be responsible for the fees for such services.

I am ☐ able ☐ unable to render the standard fee(s) of $150 per diagnostic assessment, $100 per individual counseling session and/or $30 per group counseling session provided by Lena Pope Counseling Services.

I am, however, able to pay the amount of _____% of the standard fee(s). I agree that if my financial situation changes or insurance coverage ends during the time services are being provided I will begin paying the new fee, according to the financial assistance scale.

Client/Parent Signature _____ Date _____

Lena Pope staff signature _____ Date _____

If you are unable to pay the standard fee, please complete the following section: (a reduction in fees is subject to verification of eligibility and availability of funds)

I am unable to pay the standard fee due to: ☐ unemployment ☐ insufficient income
☐ homelessness ☐ Other: _____

Please initial all that apply:

_____	Income	I attest to the fact that I do not have the documentation necessary to determine my income for admission to Lena Pope funded services.
_____	Insurance	I attest to the fact that I do not have insurance, or any other assistance for admission to Lena Pope funded services.
_____	Employment	I attest to the fact that I do not have employment, or any other income, for admission to Lena Pope funded services.
_____	Identification	I attest to the fact that I do not have any form of identification; i.e. photo ID or birth certificate at this time.
_____	Residence	I attest to the fact that I do not have a permanent residence, but do reside in the state of Texas.

Name of resident with whom I reside _____

Resident's home phone: _____

Resident's address: _____

City, State, Zip code: _____

I wish this certification statement to attest to the fact that my financial summary contains an accurate assessment of my income and expenses and shows that I am unable to fully pay for Lena Pope/DSHS funded services.

I _____, certify that at this time all statements noted above are accurate.
(Client/Parent Name)

Client/Parent Signature _____ Date _____

Lena Pope staff signature _____ Date _____

LENA POPE | Counseling Services

Cancellation Policy Reminder

We would like to remind all clients of the Lena Pope policy regarding the cancellation and rescheduling of appointments. We would like to remind you of a few points:

- Please remember to notify your therapist at least 24 hours in advance if you know that you are going to be unable to keep your scheduled appointment. There is a $25 fee for missed appointments, as well as appointments cancelled with less than 24-hour notice. When you commit to an appointment time, that time is reserved for you, and therefore other clients are unable to schedule an appointment at that time. Due to the high volume of clients waiting to be seen and waiting to begin counseling services we ask that you show consideration to your therapist and these clients, as your last minute cancellation prevents therapist from offering your appointment to another client in need of services.

- Individuals who miss two appointments without prior notification are subject to removal from the appointment calendar. While we understand that emergencies happen that prevent you from keeping your appointment at times, please be mindful of your commitment to your appointment and do not allow this to happen often. Therapists are instructed by their supervisor to not reschedule clients who miss two or more appointments without providing 24-hour notice for the cancellation. Therapists will not have the discretion to reschedule clients without supervisor's approval.

- If you need to cancel or reschedule your appointment please contact your therapist directly, or call the main Lena Pope office at 817-255-2652. If you know you need to cancel during non-business hours, please leave a message to ensure that your cancellation time is received within 24-hour notice timeframe.

- Individuals arriving later than 15 minutes for a scheduled appointment are considered a no-show and will be unable to be seen for that scheduled session.

Client signature

Date

LENA POPE | Counseling Services

CLIENT COPY

General Information

It is our belief that we can establish a better relationship and serve you more effectively if you are familiar with the procedures of this program. We believe in continuous improvement in the quality of services that are provided at Lena Pope and may ask you to assist us by completing a satisfaction survey. These are available at the front desk. Please be advised that a staff person may be calling you after counseling services has ended for follow-up and aftercare.

APPOINTMENTS AND SCHEDULING

Based on the need and the assigned program, clients are seen in the office, home, or community. Lena Pope acknowledges the value of Emotional Security Animals (ESAs), however ESAs are not allowed in any Lena Pope offices. Individual appointments are generally fifty-minute sessions. Groups are typically 90 minutes. To contact someone about rescheduling or cancelling an appointment call **(817) 255-2652**. All telephone calls will be returned as soon as possible. **Arriving more than 15 minutes late for a session may result in loss of your appointment.**

We ask that you call our office at least 24 hours in advance if you need to cancel or reschedule. There is a $25 fee for missed appointments, as well as appointments cancelled with less than 24 hours' notice. Individuals who miss two appointments without prior notification during treatment are subject to removal from the appointment calendar.

In case of bad weather, your therapist will call if the office closes and your appointment needs to be rescheduled.

If you have a medical emergency, call 911. If you feel a non-medical emergency exists and it is after office hours, please call your county's Hotline Number listed: Tarrant County 1-800-866-2465 or text 817-335-3022 and for Hood / Parker Crisis Hotline 1-800-772-5987

CONFIDENTIALITY

Lena Pope staff take every reasonable measure to ensure your confidentiality. However, confidentiality and privileged communication are limited under Texas law and professional codes of ethics. Lena Pope staff are required to report any suspicions or evidence of child abuse; abuse of those who are elderly or disabled; a person's intent to take harmful, dangerous, or criminal actions against another human being or against him/herself; and sexual exploitation by a mental health provider.

PHILOSOPHY

The practice of counseling requires mutual understanding, respect, and confidence. We look forward to providing you services with the highest professional standards of counseling. Lena Pope uses evidence-based practices and programs. Depending on the program that you are enrolled in, services can include screenings, assessments, individual, family, couples, group counseling, school or community-based groups, and in-home counseling. Your therapist will discuss his or her personal method of treatment and will help you decide on goals for your treatment.

Your therapist will help you decide if including family members or significant others in your treatment will assist you in reaching your goals. It is also important to understand that participation in counseling can lead to individual changes that could affect your relationships and interactions with others in both positive and negative ways. If you wish, your therapist can discuss alternate forms of treatment for your concerns.

LENA POPE | Counseling Services

TREATMENT OF MINORS

Parents and legal guardians have the right to request information concerning a minor's evaluation and treatment. We will protect the rights and confidentiality of all minors and therapists use their discretion in communicating information disclosed by minors in private. Risky behaviors such as drug use, running away or self-harm will be reported to parents/legal guardians. Your therapist will further discuss the issue of confidentiality of minors prior to beginning services.

GRIEVANCE PROCEDURE

I understand no one can punish, threaten or discriminate against me for using or helping someone else file a complaint or grievance.

I understand that if I am not satisfied with any decision regarding my complaint, that I have the right to appeal the decision to the next highest level and to the Executive Director of Lena Pope.

The following is a list of steps of the grievance process:

a. When a client wishes to make a complaint, he/she may either request a form from his assigned family Specialist/Therapist or request one from the receptionist at 817-255-2652, which he/she fills out completely and signs. The client may request writing materials, postage, and access to a telephone for the purpose of filing, as well as request assistance in completing the form from the Counseling Services staff. The client may also directly file the grievance with DSHS at the following address:

   Texas Department of State Health Services
   Department of Investigations
   PO Box 149347
   Austin, TX 78714
   Or by phone at:
   Phone: 512-349-6749
   Or Toll Free: 800-832-9623

b. After completing the form, the client turns it into a Supervisor or Counseling Services Director. If there is an issue that may require more immediate attention, the grievance and the copies should be distributed to the appropriate persons as soon as possible.
c. The Counseling Services Supervisor or Director will evaluate the grievance thoroughly and objectively, obtaining additional information as needed. The Supervisor or Director will respond with proposed resolution within seven working days and notify the client making the complaint.
d. Copies of outcomes are sent to the Executive Offices.
e. The Supervisor or Director will send to the Executive Director and the Director of Human Relations a copy of the grievance form as complaints are received. All department grievances will be maintained in a central file in the counseling department.

Lena Pope Counseling Services

Notice of Privacy Practices Revised 09/01/14

www.lenapope.org
817-255-2652

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your records are protected under HIPAA and cannot be disclosed without written consent unless otherwise provided for in Federal and State regulations. Your records may also be protected under the Federal Regulations governing the confidentiality of alcohol and drug abuse client records, 42 CFR Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulation.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this Notice: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

Client information is shared as needed for the purpose of treatment, payment and operations, including coordination of care with other programs or services provided by Lena Pope.

Client information is shared with the primary care physician for the purpose of coordination of care.

For additional information or questions, please contact Stacey Lewis, Director, at 817-255-2655.