NextGen
Counseling, PLLC

Thank you for choosing NextGen Counseling, PLLC! We look forward to working with you. Please complete this packet in its entirety at least 24 hours prior to your scheduled session with provider. If you have questions concerning completion of packet please email jessica@nextgencounseling.org or call 940-228-2171.

NextGen Counseling, PLLC

CLIENT INFORMATION

Name of Client: _____ Today's Date: _____

Address: _____City:_____ Zip Code: _____

Phone Number: _____ Text Message ok?

E-Mail Address _____ # of children _____

Marital Status _____ Age _____ Birthday _____/ _____ / _____

Employment: _____ Drivers License # _____

Emergency Notification _____
Name Relationship Phone

If client is a minor, please provide other parent's contact information (Note if divorced, we will need a copy of the divorce decree for our records as mandated by the state):

_____

Name Relationship Phone Email Address

Person Responsible for Payment Information:

Name: _____ DOB: _____/_____/_____

Email Address: _____

Driver's License Number: _____ Phone Number: _____

Address (if different) : _____

Employer _____ Employer's Phone Number: _____

How did you find us? _____If Referred, by whom: _____

If Referred, may we thank them? _____ yes _____ no

What is your chief concern at this time? _____

_____

What if any stressful life events have recently occurred? _____

_____

_____

Please check any current symptoms you are experiencing.

____ Decreased Energy	____ Panic Attacks	____ Intrusive/Negative Thoughts
____ Guilt	____ Excessive Worry	____ Concentration Problems
____ Sleep problems	____ Anxiousness	____ Obsessions/Compulsions
____ Hopelessness	____ Worthlessness	____ Relational Difficulties/Conflicts
____ Eating Problems	____ Impulsivity	____ Hyperactivity
____ Tearfulness	____ Irritability	____ Inappropriate anger
____ Mania	____ Delusions/Hallucinations	____ Self Injurious Behavior
____ Depression	____ Increased Alcohol Use	____ Use of Illegal Substances
____ Thoughts of Death/Suicide	Other Symptoms _____	

When would you estimate that these symptoms began? _____

_____

What has been the course of your symptoms? (i.e. getting better, worse, or staying the same) _____

_____

Have you experienced similar symptoms before? When? _____

_____

What have you tried that has made the symptoms better/worse? _____

_____

What (if any) psychotropic medications are you taking, or have you tried? _____

_____

What (if any) medications are you currently taking (please include vitamins and OTC)? _____

_____

Date of last physical checkup: _____ Recent hospitalizations: _____

Have you consulted other health professionals concerning your symptoms? List names and dates of counseling as well as problems addressed: _____

_____

Do you smoke? Y N Do you consume alcohol? Y N How many drinks per week? _____

Have you ever used an illegal substance or legal substance illegally? If so, please share when and for how long. (Substance use can create or influence depression/anxiety) _____

_____

Do you have a supportive and/or spiritual community? Explain _____

_____

Briefly describe your relationships in your family of origin (close, distant, conflicted): _____

_____

Briefly discuss any mental health or addiction issues that have occurred in your family dating back to grandparents: _____

_____

Briefly describe your current significant relationships (friends and/or significant others): _____

_____

Have you ever been the victim of abuse or experienced a traumatic event (child abuse – physical, verbal, sexual, rape, crime victim, bullying, or any significant event that impacted way you view yourself or your world?

_____

_____

_____

PLEASE REVIEW IMPORTANT NEXTGEN COUNSELING POLICIES BELOW:

-WHAT IS INVOLVED IN THE COUNSELING PROCESS?

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. It requires a very active effort on the part of both the client and therapist. In order to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy has shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Each individual's progress varies.

Our first session will involve an evaluation of your needs. By the end of the evaluation, your counselor will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with him/her. If you have questions about procedures, they should be discussed – no concern is too small if it affects the counseling relationship. If at any time you feel that the issues discussed have not been resolved to your satisfaction, please feel free to contact our center director or ask for a referral. If you decide to proceed with counseling, usually a session **lasts 50 minutes in duration**. Some sessions may be longer or shorter depending on your specific needs and treatment goals. **Once this appointment session is scheduled, you will be expected to pay your therapist's full session rate unless you provide 24-hour advance notice of cancellation with the exception of extreme emergencies (accidents, emergency illnesses, etc.)** If you arrive more than 15 minutes late to an appointment, the session will be considered missed unless other arrangements are worked out with your therapist. Work conflicts would not be reasons for this fee being waived. Frequent cancellations and rescheduling may result in termination and referral by your counselor and will be discussed by phone or in person before this occurs. If a minor child or client being covered by a guardian's insurance policy (thus making them the guarantor) incurs fees, the guardian/guarantor will be held legally responsible for any fees occurred including cancellation fees.

-WHAT FEES ARE INVOLVED IN THE COUNSELING PROCESS?

My standard fee is ***$150 for an initial session, $125 for a 50-minute session and $60 for a twenty-five-minute session*** (The actual cost to you may vary due to sliding scale agreement if agreed upon). Please note that at NextGen Counseling PLLC we **DO NOT ACCEPT INSURANCE** and would be classified as an Out of Network Provider should you choose to submit to your insurance provide. The client is responsible for filing any out of network claims for reimbursement and we cannot promise that insurance will reimburse for session payments. Please review **attached fee sheet** for other fees that may be incurred for services provided on client's behalf. You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested. Payment can be made in the form of cash, credit card, or a personal check. ***Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements and an interest rate of 18 % will be added to all outstanding balances including those created by returned checks***. **There is a $25**

returned check policy. Committing check fraud is a felony and if a returned check is not cleared within a month, this matter may be turned over to the Denton County District Attorney's Office for Prosecution and will definitely be turned over to our check recovery service. If an unpaid balance does occur, this can be turned over to a credit recovery service which may report medical collections to the standard credit reporting agencies adversely affecting a client(s)' credit score.

COURT RELATED FEES: I have no forensic experience and being a master's level counselor or intern would generally not be considered an expert witness. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involved CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge **$250 per hour** for preparation for and attendance at any legal proceedings. Also, a **$1500** retainer will be required up front if a subpoena is issued or court appearances are requested. If a client is involved in a lawsuit that creates a situation where we are court ordered to be involved we are happy to bill the initiating party for services rendered. If the charges are not paid at the time of services rendered, the fees will become the client's responsibility.

IS WHAT WE DISCUSS CONFIDENTIAL?

In general, the confidentiality of all communications between a client and a therapist is protected, and a counselor can only release information about what occurs during session to others with written permission. However, there are a number of exceptions including some legal proceedings. If a staff member believes that a client presents a **danger to him/herself or to someone else**, he or she is required to take protective actions. If a **child, an elderly person, or a disabled person is suspected of being abused**, a report must be filed with the appropriate state agency. Should such a situation occur, every effort will occur to fully discuss the concerns before taking action. **If interactions reveal that the client is a danger to themselves or others, their emergency contact will be notified or the local authorities.**

Understand that confidentiality is not the same as statutory privilege. If a legal subpoena is issued by the court or if you've given permission for exchange of information for insurance purposes, details regarding sessions may be disclosed. It is the center's policy to make every effort to contact you first should this occur. Please refer to the disclaimers on our Release of Confidential Information form.

To ensure you receive the excellent ethical care, generic case situations are staffed during private meetings and/or supervision. In these consultations, every effort is made to avoid revealing identifying information. The consultants are, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. All interns and practicum students are involved in weekly supervision sessions where your identity will remain obscured but your case will be discussed in detail.

ADDITIONAL EXCEPTIONS

****Please note that any individual attending group, joint marriage sessions and/or any family sessions has access completely to the records of that session.****

• **MARRIAGE COUNSELING:** If you are involved in marital counseling, confidentiality does not

include your spouse and is left up to your counselor's discretion. This will be explained further in your initial session.

• **PARENTS OF ADOLESCENTS:** ***If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, a need to discuss these activities with their parent will be discussed. The minor will then be given the opportunity to inform their parent/guardian during the counseling session of behaviors that are deemed by the counselor a harm to self***. Please understand that we will not betray confidences of parental defiance or rebellion that are not life threatening. We will make every effort to encourage the minor to be forthright with their guardians as transparency is a recognized dynamic of a healthy relationship. If a parent feels betrayed by our keeping of confidentiality, we encourage the family to schedule a family session to discuss this matter.

• **PARENT CONSULTATIONS**: Also, in counseling involving a minor child as the identified patient, the rights of confidentiality extend to them only. If you share information during a parent consultation that would impact their treatment or if the child is present, realize that either parent has access to the child's records and anything said by the other parent would not be considered confidential during a family session or parent consultation since they are not a counseling patient.

• **LEGAL ISSUES:** If at any time you involve any staff member or NextGen Counseling, PLLC as a company in legal proceedings including but not limited to requesting files for an attorney, having a subpoena issued by an attorney or court, requesting a staff member give a deposition, or verbally or in writing threatening to name a staff member or the organization in a lawsuit, we will disclose general case information to our attorney in order to follow best legal and ethical practices when addressing these issues.

**While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. The laws governing these issues are quite complex, and your counselor is not an attorney. Should you need specific advice, formal legal consultation is strongly recommended*

ELECTRONIC COMMUNICATION:

It is against HIPAA standards for us to contact you electronically using text or email that is not encrypted. If you so choose to use this means of communication, your counselor will not reveal or respond in any manner regarding counseling PHI (protected health information). Please make sure you keep records of your appointment schedule – last minute contacts to verify date and time that result in your not keeping an appointment will result in a cancellation fee. Occasionally, we realize urgent matters arise and brief message sent by text or email regarding a scheduling issue may occur. Please understand that information exchanged this way is NOT protected. If you wish for your counselor to respond in an urgent situation, please initial here. Also, if your counselor does not respond, you will need to follow up with a phone call and leave a message. It is your responsibility to confirm their receipt of any information sent by text or email.

HOW ARE MY RECORDS MAINTAINED AND RECEIVED IF REQUESTED?

Both law and the standards of my profession require that appropriate treatment records are kept. You are entitled to receive a copy of the records. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, it is recommend that you review them in your counselor's presence so that we can discuss the contents. Most often a summary is supplied because handwriting and notes are for the counselor's use in treatment and may be difficult to understand clearly. Clients will be charged $100 an hour for any preparation time required to comply with an information request including a minimum fee of $50 and must give two weeks notice to allow for these records to be prepared. (Please see Fee Agreement (Exhibit A) for further explanation of fees charged). Files are shredded six years after the date of our final session or in compliance with State Board and HIPAA guidelines.

WHAT DO I DO IN THE EVENT OF MY COUNSELORS SUDDEN LEAVE DUE TO ILLNESS OR DEATH?

If for any reason your counselor would become unavailable due to illness, injury, or death, please contact Jessica Burrows, MA, LPC, CFLE, Clinic Director, at 972-971-6383. If she is not available, please contact Burrows Law Group at 972-304-6000. The Clinic Director, Jessica Burrows, MA, LPC, CFLE will become custodian of all files that have not been destroyed in the event of a staff members death or illness. In the event of the death of Clinic Director, Jessica Burrows, MA, LPC, CFLE, the Burrows Law Group located at 2900 Village Parkway, Suite 200, Highland Village, Texas 75077 will be the custodian of all records of Jessica Burrows, MA, LPC, CFLE. Burrows Law Group may be reached at 972-304-6000.

HOW DO I CONTACT MY COUNSELOR?

Our main number is **940-228-2171.** Your counselor will provide a business card with their contact information and it is also listed on the website: www.nextgencounseling.org . Every effort will be made to return your call by the end of the next business day with the exception of weekends and holidays and otherwise noted on your counselor's outgoing message. **In emergencies, 911 or an emergency room should be utilized. You can leave a message after contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility**.

ART THERAPY

At times, art therapy may be used in your treatment, especially that of children and adolescents. Examples of artwork done in therapy may be used with permission during professional trainings. All markings of identity are disguised and names are changed to protect the identity of the clients. **Please initial here giving permission for any artwork created during counseling to be used for professional training only. _____**

GIFTS

Please understand due to ethical standards set forth by the state of Texas and professional counselor associations, it is the center's policy not to receive gifts valued at above $50.00

COUNSELING CONTRACT

I, the client(s) signed below, affirm the accuracy of the personal information provided herein, and have read the information above and agree to the conditions set forth therein. I hereby agree to the following conditions:

1. I am committed to changing my life by making positive choices.

2. I will keep the appointment time, or will call to cancel 24 hours in advance with a legitimate excuse.

3. I will fulfill the homework assignments.

4. I will begin to build a support network outside of the counseling office in order to sustain personal growth.

5. I understand that confidentiality cannot be guaranteed as indicated in the previous pages including limits regarding harm to self or others, supervision and consultation, marriage and family counseling, legal issues, and electronic communication.

6. I understand that early termination of counseling is required in writing and it is most beneficial to exit counseling with a closure session.

7. I understand that I am financially responsible for any fees/co-payments incurred. I am also responsible for any fees not covered due to my not following the procedures set up by my insurance provider if applicable or not providing the information in a timely manner for billing purposes. I understand that I am responsible for any fees not covered by insurance. I also understand that if I am the guarantor of a minor/client, I am responsible for any fees they may incur.

8. I understand that if I am seeing an intern/student that they are under supervision and require weekly visits with their supervisor who will review your case and assist them in providing adequate treatment.

9. I also acknowledge receipt of **Notice of Policies and Practices to Protect the Privacy of Your Health Information and NextGen Counseling, PLLC Informed Consent.**

10. **I acknowledge that if I am the signing on behalf of a minor child, I am their legal guardian and have the power to give medical/psychological consent.** I have been informed a copy of my divorce decree proving the above is required for any follow up visits. I also am aware of NextGen Counseling, PLLC's philosophy that making a counselor reveal records or appear in court is rarely therapeutic for children participating in therapy because it destroys their safe place.

(Signed)_____ (Date) _____

NextGen Counseling, PLLC

Licensed Professional Counselors and Interns

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Health Care Operations"

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• *"Use"* applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "*Disclosure"* applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

• **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

• **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.

• **Health Oversight:** If a complaint is filed against one of our counselors with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.

• **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for

information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
• Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to your emergency contact or medical or law enforcement personnel.
• **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

• *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we will send your bills to another address.)
• *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
• *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
• *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties:

• We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
• We reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
• If we revise our policies and procedures, we will post notice of such revision on our practice web site, http://www.nextgencounseling.org . We may also elect to notify you by mail at the billing address which you have provided to us.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact:
Jessica Burrows, M.A., LPC, Privacy Officer for NextGen Counseling, PLLC:
By email: jessica@nextgencounseling.org or by phone at: 940-228-2171
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on February 1st, 2014

NextGen Counseling, PLLC
CONSENT FOR TREATMENT OF MINOR DEPENDENT
940-228-2171 phone 940-228-2173 fax

Consent for Treatment of Minor Dependent

RE: _____ Birth Date: _____
Last Name, First, Middle

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child, I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from the staff of NextGen Counseling, PLLC. I further certify that I have full legal authority to authorize and consent to this evaluation and/or treatment.

Signature: _____

Print Name: _____

Date: _____

NextGen Counseling, PLLC
RELEASE OF CONFIDENTIAL INFORMATION
940-228-2171 phone 940-228-2173 fax

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

I do hereby consent and authorize _____ to disclose to:

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____

Otherwise confidential information pertaining to my treatment:

☐ By transmitting a copy of my confidential health record in full.

☐ By transmitting a treatment summary

☐ By discussing and exchanging my otherwise confidential information by phone email personal contact

Restrictions or limitations on information to be released (specify):

_____

_____

I understand this information is to be used for the purpose of: ☐ Diagnosis ☐ Continuity of Care ☐ Legal Purposes ☐ Treatment Planning ☐ Discharge Planning ☐ Further Evaluation ☐ Insurance Claim(s) ☐ Other

- This Authorization may be withdrawn at any time in writing except to the extent that the person(s) which are to make this disclosure have acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires one year, except for information to be released or exchanged for purposes of a claim for benefits. If for a claim for benefits, this release of information expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.
- I understand that I am financially responsible for costs involved in this request as outlined in my signed Inform and Consent with Allen Counseling Associates. I understand that if a subpoena is issued for court appearance, I am required to provide ACA a financial retainer before the date of the court appearance.
- To the party receiving this information: If the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, confidential communicable disease information, and/or psychiatric mental health information, the information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) or by Texas law. The Federal and state rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I understand that the information to be released may contain confidential HIV/AIDS related information, confidential communicable disease information, information relating to drug/alcohol use/abuse/treatment and/or psychiatric mental health information. I authorize the release of the above indicated confidential information. I understand that, if this Information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization who receives the information.
- I understand the matters discussed on this form. I release the provider, officers and directors, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- A copy of this executed release serves the same purpose as an original.

EXECUTED ON THIS DATE: _____
Patient or Guardian Signature: _____

☐ Check here if you are the legal guardian for the party whose information is to be released.

NextGen Counseling, PLLC

Fee Agreement

Counseling Rates

• Initial Intake Session	(60 minutes)	$150
• Individual Session	(50 minutes)	$125
• Consult- Check In	(25 minutes)	$60
* Reduced fees based on income		
	(50 minutes)	$100
	(50 minutes)	$85

If reduced fee agreed upon, please circle fee and initial here _____

• Double Session	(1 hour 30 minutes)	$250

Document/ Appearance Fees

• Copy of Session Notes	($50 copy fee)
• Treatment Summary	($50 document fee)
• Disability Claim Documentation	($50 document fee)
• Letter Requests	($50 document fee)
• Court Appearances	($1500 Retainer/ $250 hourly minimum)

Phone Calls/ Communication

• 25 minute phone call ($60.00 per call)

Any calls that are over 25 minutes are billed at normal session rate

Payment and Insurance

- Payment is due on the day of your session.
- We take all major credit cards, check, and cash.
- We provide a statement/invoice upon request from client.

24hr Cancellation Policy

- We require a 24-hour cancellation notice or rescheduling request
- If you do not give 24-hour notice the credit card we have on file will be charged the FULL FEE of the appointment.

Client/Parent Signature _____ Date _____

Phone: 940-228-2171 Fax: 940-228-2173

www.nextgencounseling.org jessica@nextgencounseling.org

NextGen Counseling, PLLC
Communications Policy

Preference for Confidential Communications:
As per the Notice of Privacy Practice, you have the right to request that this office communicates with you about your health information in a certain way or at a certain location. For example you can request to be contacted by mail or at work. Please indicate where you would like to be contacted:

I prefer to be contacted by: ☐ Phone ☐ Email ☐ Texting ☐ Mail

I prefer to be called and/or texted at the following number:_____

I ☐ DO ☐ DO NOT want messages to be left at this number.

Please only call at these times: _____

I prefer emails to be sent to: _____

I prefer texts to be sent to: _____

I prefer mail to be sent to: _____

Email, Texting, Online Platforms, and Applications
Your protected health information must be kept private and secure according to federal and state laws and professional ethics codes. Email, texting, online platforms, and applications are convenient ways to communicate for treatment purposes (such as discussing your current symptoms) and administrative purposes (such as appointment scheduling and billing). Reasonable means to protect the security and confidentiality of communications via email, texting, online platforms, and applications will be taken. **However, it is impossible to guarantee the security and confidentiality of communication via email, texting, online platforms, and applications.** Should confidential information be improperly disclosed, through no fault of this office, this office will not be liable for such disclosures.

Potential risks of communicating by email or text may include:

- Misdelivery of emails or texts to an incorrectly typed address or number.
- Email and online accounts and phones can be hacked.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email, texts, and online platform or application data may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect emails, texts, online communications and application data transmitted through their systems.
- Information sent via emails, texts, online platforms, and applications can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails, online platforms, and applications can be used to introduce viruses into computer systems.
- Emails, texts, and online platform and application data can be used as evidence in court.

All emails and texts to or from patients concerning diagnosis or treatment will be filed as part of the patient record. Since the information will be considered part of the record, other individuals authorized to access the record, such as staff and billing personnel, will also have access to those emails. Note that all email is

retained in the record of the system sending the email. Emails and texts may be forwarded internally to workforce members as necessary for diagnosis and treatment.

COMMUNICATION VIA EMAIL, TEXT, ONLINE PLATFORM, OR APPLICATION SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

You have the option of choosing whether to communicate with this office via email, texting, online platforms and/or applications and what information you wish to communicate. **You do not have to consent to communication via email, texting, online platforms, or applications** and communication can be handled in person or via phone call or mail. You may revoke any permission at any time by writing the office.

By consenting to communicate through email, text, online platform or application, you also agree to the following responsibilities:

- If you send a communication that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify the office that the communication was not received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule appointments.
- To the extent possible you should NOT use email, texting, online platforms, or applications to make disclosures about sensitive medical information such as: mental health treatment, drug, alcohol or substance abuse, information related to AIDS and HIV, and genetic information.
- It is your responsibility to inform the office of any changes to your communication preferences including changes in mailing address, phone number, email address, or online account usernames.

Email: I ☐ DO ☐ DO NOT consent to use **email** for

☐ Administrative Purposes and/or ☐ Treatment purposes.

Other Conditions for **emailing**:_____

Texting: I ☐ DO ☐ DO NOT consent to use **texting** for

☐ Administrative Purposes and/or ☐ Treatment purposes.

Other Conditions for **texting**:_____

Online Platforms: I ☐ DO ☐ DO NOT consent to use **online platforms** for

☐ Administrative Purposes and/or ☐ Treatment purposes.

Other Conditions for **online platforms**:_____

Applications: I ☐ DO ☐ DO NOT consent to use **applications** for

☐ Administrative Purposes and/or ☐ Treatment purposes.

Social Media

I have a professional Facebook page at https://www.facebook.com/NextGenCounseling.org and a professional Twitter account at https://twitter.com/nextgen4325. If you choose to "like me" on Facebook or "follow" me on Twitter, I assume that you are making an informed decision about how this may compromise your confidentiality. My fan list on Facebook and follower list on Twitter are public information and easily accessed by anyone on the internet. The vast majority of my fans and followers are not clients, however there is a small risk that you could be identified as a client simply based on your decision to like or follow me.

Blog

I maintain a professional blog about counseling topics at https://www.nextgencounseling.org/news--blog. Clients are welcome to read my blog, comment and sign up for email notifications. However, similar to social media, please be cautious that in leaving any comments on my blog you may compromise your confidentiality. Any comments that divulge personal information will be edited at my discretion.

Email Newsletter

I send an email newsletter to subscribers typically once a month. The newsletter typically includes one article about counseling related topics. If you are interested, you can sign up on my website. Many of my subscribers are not clients and **clients are not required to subscribe**. As with other online communications, there are privacy risks. I do not sell, lend, or rent my mailing list.

I may use my newsletter to promote new services I offer including workshops. By subscribing to my email newsletter, you are opting to receive such marketing communications. You may opt out of receiving these emails by clicking the "unsubscribe" link on the email or by contacting the office in writing.

Business Review Sites

I have listings on Google and Facebook, both of which include options for users to rate their providers and add reviews. These listings are not requests for testimonials, ratings, or endorsement from you as my client. You have a right to express yourself on any site you wish. But due to confidentiality laws, I cannot respond to any review on any site whether it is positive or negative. And like my blog and other online communications, there are privacy risks.

I recognize that technology is ever evolving and that electronic communications cannot be fully protected from unauthorized interception. Understanding the risks of electronic communication via email or texting, I have indicated my preferences and consent for communications.

Client/Patient Signature	Date
Personal Representative Signature (if applicable)	Relationship to Client/Patient
Minor Signature (if applicable)	

NEXTGEN COUNSELING, PLLC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

I acknowledge that NextGen Counseling, PLLC provided me with a copy of their Notice of Privacy Practices and that I am aware the Notice of Privacy Practices can be found on the web at www.nextgencounseling.org.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian (if patient is a minor) Relationship to Patient

NextGen Counseling, PLLC
www.nextgencounseling.org
(940)228-2171 phone (940)228-2173 fax

CREDIT CARD INFORMATION for Clients Using ON FILE Method

In order to hold your scheduled session a credit card is required to be on hold with Next Gen Counseling. Please note that we keep all credit card information locked in our secure filing cabinet behind double locks at all times with your client file.

Please remember that you are responsible for the fee even if you cancel your appointment, unless cancelled at least 24 hours in advance of your scheduled session. By signing below, you are authorizing your card to be used for all cancellations, no shows, scheduled sessions, and other services outlined in the fee agreement (records request, parent consults, etc.).

Name on Card: _____

Card Number: _____

3-digit verification code (back of card): _____

Zipcode: _____

Card Expiration: _____/_____

Authorized Signature to use Card:

_____

Responsible Party Signature

_____

Responsible Party Printed Name