832-303-3082
www.NewFocusCounseling.com

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Practice Policies

Welcome to New Focus Counseling Alliance, Inc. and thank you for choosing this practice for your counseling and therapeutic needs. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement.

Counseling Process: Counseling is a collaborative and interactive process between the client and clinician. Each client is an individual with personal characteristics, life histories, preferences, and experiences that make them uniquely who they are. Being an active participant in the therapeutic process is strongly encouraged. Each one of our providers is an independent clinician practicing within New Focus Counseling Alliance, Inc. Every clinician holds a minimum of a master's level of education from an accredited program, college, or university, has an active professional license to practice in the State of Texas, and has passed a background check. Each clinician has a chosen therapeutic style and practice unique to them, so it is important to us that we match you with a clinician who can best meet your specific needs. Please discuss your clinician's approach, style, process, specialties, and practice during your initial session. Unless otherwise indicated by your clinician, your sessions will be scheduled in Central Standard Time (CST).

Fees: Insurance: Session fees using insurance benefits can range from $150 to $400 or more. If you choose to utilize insurance or Medicaid benefits, you will be responsible for any deductibles, co-payments, coinsurance or any variation thereof dictated and/or mandated by your insurance carrier. The admin team at New Focus Counseling Alliance, Inc. will verify insurance benefits, submit claims, and receive payments on behalf of your clinician. Please speak with your office administrative team, your insurance carrier, and/or your clinician regarding any questions regarding claim submission, accounts receivable, and account payables. **Private Pay Rates:** If you choose not to utilize your insurance or Medicaid benefits or if you are uninsured, you have the option to be seen as a private pay client. Private pay rates are as follows for fully/unrestricted licensed clinicians (LPC, LMFT, LMSW, LCSW):

Individual (one client) therapy sessions

-$200 for initial session (must be 60 minutes)

-$150 per each additional session (can be 45- or 60-minute sessions)

Couples, dyads, two client family therapy sessions

-$250 for initial session (must be 60 minutes)

-$200 per each additional session (60 minutes)

Three or more client's family or relationship therapy sessions

-$275 for initial session (must be 60 minutes)

-$225 per each additional session (60 minutes)

*Professional services include, but are not limited to office appointments, telehealth appointments, third party consultations, written and verbal correspondence, and professional reports. *Phone consultations lasting longer than 15 minutes will result in a session fee. *Please provide at least 24-hour notice of appointment cancellation to avoid a $75 late cancellation fee. Please attend your scheduled session appointments to avoid a $75 no show fee. Your session will be canceled if you are more than 15 minutes late to your session. *Payment in the form or credit card, debit card, personal check, cashier's check, or money order is due at the time of service. All checks are to be made out to New Focus Counseling Alliance, Inc. *Returned checks will be charged an additional $25.00.

Request for Records: Requests for records must be submitted in writing to your clinician. Once the written request is received, your clinician will attend to your request according to their licensing guidelines. The first 20 pages will incur a charge of $25. Each additional page will incur a charge of $0.50 per page. Documents requiring a Notary will incur an additional charge of $15. You may submit your payment to New Focus Counseling Alliance, Inc. and your clinician will be notified of your payment.

Cancellations/No Shows: Please provide at least 24-hour notice for cancellation and/or rescheduling of an appointment. You may cancel through your secure on-line portal, through your clinician directly, or by contacting the administrative office. Failure to provide at least 24-hours' notice will result in a late cancellation fee of $75. Please attend your scheduled sessions. Failure to attend your scheduled appointment will result in a no-show fee of $75. Please note your session will be canceled if you are 15 minutes late to your appointment. Late cancellation and no-show fees can be charged to the payment method on file by your clinician, New Focus Counseling Alliance, Inc. admin, or paid by you in the form of credit or debit card not on file, personal check, cashier's check, or money order.

Insurance: If you request that your services are billed to your insurance carrier, please complete the Insurance Authorization and Release. You are responsible for all fees not covered or reimbursed by your insurance benefits, including but not limited to deductibles, co-payments, co-insurance, missed appointments, late cancellations, correspondence/reports or services not approved by your plan. Any non-covered fees will be charged to the payment method on file. (See Financial Policy and Agreement) If the clinician is not a provider for your insurance plan, you may have out-of-network benefits through your insurance company. If you have such benefits, the office or your clinician can provide you with a receipt that you may submit to your insurance so you can request reimbursement. You are encouraged to speak with your insurance provider regarding your specific policy and benefits.

Contacting your clinician: Although clinicians are not often immediately available by telephone, we make every effort to promptly respond to messages. Your clinician will provide you with their email address so you can reach them directly. You will also have access to the secure patient portal where you can send a message and/or request to be contacted by your clinician or admin. Additionally, you may contact the office admin team to ask a question, leave a brief message and/or request to be contacted by your clinician at 832.303.3082. Please leave an evening number since calls are often returned after hours. Because technical difficulties do sometimes occur, please call again if you have left a voice message at the office and have not received a return call by the end of the next business day. You may also send an email to Info@newfocuscounseling.com to request to be contacted by your clinician.

Emergency care: If you are experiencing an emergency and need to talk to someone immediately, call 911, a telephone crisis line, or go to the nearest emergency room.

Privacy rights: Professional ethics and legal standards require that conversations and records (even the fact that you are or have been a client) be kept confidential. However, under the following circumstances, your clinician is legally and ethically obligated to breach confidentiality: (a) if you present a serious imminent danger to yourself or others (b) in cases of apparent abuse, neglect, and/or exploitation of a child, an elderly person, or a disabled

person (c) when required by legal proceedings. If confidentiality must be breached, only the minimum amount of information will be revealed (only enough to protect you or others).

Your clinician is required to disclose confidential information if any of the following conditions exist:

1. You present an imminent danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your clinician was appointed by the courts to evaluate you.
4. Your contact with your clinician is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. You are under the age of 18 years and are the victim of a crime.
7. You are a minor and your clinician reasonably suspects you are the victim of child abuse, neglect, and/or exploitation.
8. You are a person over the age of 65 and your clinician reasonably suspects you are the victim of abuse, neglect, and/or exploitation.
9. You die, and the communication is important to decide an issue concerning a deed or conveyance, will, or other writing executed by you affecting as interest in property.
10. You file suit against your clinician for breach of duty or your clinician files suit against you.
11. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
12. You waive your rights to privilege or give written consent to limited disclosure by your clinician.
13. Your insurance company paying for services has the right to review all records.

***If you have any questions about these limitations, please discuss them with your clinician.**

Please review the *Policies and Practices to Protect the Privacy of Your Health Information* for a more extensive explanation of your privacy rights.

Complaints: If you have concerns or complaints regarding your treatment, you are encouraged to talk with your clinician first. You may also contact New Focus Counseling Alliance, Inc at 832.303.3082 by phone, or email Info@newfocuscounseling.com to discuss your situation/concern. If there is not a resolution between you and your clinician, you may contact Texas Behavioral Health Executive Council (BHEC) The Hobby Building, Tower 3, Suite 900, 333 Guadalupe Street, Austin, Texas 78701 p512.424.6500

By signing these policies, I,

1. Acknowledge receipt of the *Policies and Practices to Protect the Privacy of Your Health Information.*
2. Understand the counseling services will be provided by an independent clinician at New Focus Counseling Alliance, Inc.
3. Understand and agree to the stated practice policies as listed above and
4. Give full consent for myself to participate in psychotherapy. I certify that I have the legal right to seek and authorize treatment for myself.

Client Name Client Signature Date

Clinician Name Clinician Signature Date

Client Information

Legal Name:_____Preferred Name: _____

SS# _____ Date of Birth:_____Age:_____Gender: _____

Marital Status: _____ Sexual Orientation: _____

Address: _____ City: _____State: _____ Zip: _____

Email:_____Employer/School: _____

Occupation: _____ Home Phone: _____Work Phone: _____

Cell Phone:_____ Where do you prefer to receive calls? _____

Emergency Contact Name and relation: _____ Phone: _____

Address: _____

Individuals who live in the home:

Name	Age	Relationship

Health Information:

Please list any medical conditions you feel the clinician should be aware of: _____

_____

Please list all medications you are currently taking, including the dosage: _____

_____

Please list any known allergies: _____

Name and phone number of Primary Care Physician: _____

Permission to contact Physician. _____ Have you ever seen a mental health provider? _____

If yes, who and how long? _____

Current legal proceedings? _____ If so, is this the reason for therapy? _____

What are your goals for therapy? _____

_____

_____

Insurance Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the clinician insurance benefits otherwise payable to me. I agree to be responsible for payment of services rendered on my behalf or my dependents.

Primary Insurance:

Name of Insured:	Insured's Date of Birth	Relationship to client:
Insured's Address:	City, State, Zip	
Phone:	Employer:	Insured SSN:
Insurance Member ID	Group#:	Phone Number for Providers to Call
Client Name:	Client's Date of Birth:	Client's SSN:

Financial Policy and Agreement

Cancellation

If cancellation is less than 24 hours in advance of your scheduled session, or you do not attend your scheduled session, you agree to pay the late cancellation/no show fee of $75.00. Please note if you are 15 minutes late for your scheduled session, your appointment will be cancelled.

I authorize New Focus Counseling Alliance, Inc. to charge any incurred late cancellation and/or no-show fees to my payment method listed below, which will be kept on file. ☐

Insurance

I authorize New Focus Counseling Alliance, Inc. to charge my payment method listed below, which will be kept on file and encrypted in our HIPAA compliant platform. Any amounts not covered by my insurance company including, but not limited to co-payments, co-insurance, and insurance deductibles will be charged to this card. ☐

By signing below, I acknowledge and agree to the Financial Policy and Agreement. I further instruct my card issuer to honor any charges subject to the Financial Policy and Agreement**.**

Please provide the following information:

Name on Card: _____ Credit/Debit Card Number: _____

EXP Date: _____ CVV Code: _____ AMEX Code on front: _____

Billing Address: _____ City/ST: _____ Zip: _____

Client Consent for Use of Email Communication

For routine matters that do not require immediate response or therapeutic intervention, please feel free to email the office at Info@newfocuscounseling.com. You may also email your clinician directly. Remember, however, this form of communication:

- Is not appropriate for use in an emergency.
- Is a means of communication, but not a therapeutic venue.

Should you require urgent or immediate attention, this means of communication is not appropriate.

New Focus Counseling Alliance, Inc. will use reasonable means to protect the security and confidentiality of e-mail information sent and received.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to electronic communication. When communicating from your place of employment, some employers consider e-mail corporate property, and your messages may be monitored. If you are using a shared device, please be aware your email messages may be viewable by others also using that device. Additionally, you should be aware that although messages are addressed to your clinician, administrative staff and/or other clinicians may have access to this information. If you provide an e-mail address to us or initiate e-mail contact with us, doing so constitutes your authorization for us to communicate with you via e-mail to your indicated return e-mail address.

Your signature below indicates your understanding of the potential privacy limitations and the guidelines of communication via e-mail with this clinic and its contractors and/ or employees. I understand that New Focus Counseling Alliance, Inc., and all contracted clinicians and employees will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond control or improper disclosure of confidential information that is NOT caused by the intentional misconduct of New Focus Counseling Alliance, Inc., our employees, and contractors. I understand and agree to the above email policy. I understand the risks associated with communication via e-mail, and consent to the conditions herein.

Client Signature	**Client Printed Name**	**Date**

Client Email Address

Therapist Signature	**Therapist Printed Name**	**Date**

Telemental Health Informed Consent

I _____(name of client) hereby consent to participate in Telemental health with_____ (name of clinician) as part of my psychotherapy. I understand that Telemental health is the practice of delivering mental health care services via technology assisted media or other electronic means between a clinician and a client who are in two different locations.

I understand the following with respect to Telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks and consequences associated with Telemental health, including but not limited to: disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons around me if not in a private area, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemental health unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemental health services are not appropriate, and a higher level of care is required.

6) I understand that during a Telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will contact you to reschedule the remainder of the appointment.

7) I understand that my clinician may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8) I understand our Telemental health sessions occur in the State of Texas, (USA), and is governed by the laws of the State of Texas.

Emergency Protocols:

Your clinician needs to know your location in case of an emergency. You agree to inform your clinician of the address where you are at the beginning of each session. Your clinician will also need a contact person whom they may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:_____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my clinician. I understand the information contained in this form and all my questions have been answered to my satisfaction.

Printed Name of Client:	Signature:	Date:
_____	_____	_____
Printed Name of Clinician:	Signature:	Date:
_____	_____	_____