

Abbie Cottle Smith Counseling
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abbiesmithcounseling@gmail.com

Abbie Smith
••••• Counseling

Abbie Cottle Smith is a Licensed Professional Counselor, working as an independent contractor of Flower Mound Counseling. I provide individual, family, and group counseling to clients. I have a BBA in Marketing from Tarleton State University, and a Masters in Professional Counseling from Amberton University.

Confidentiality: I am committed to confidentiality to the fullest extent allowed by Texas law. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies **without your permission**. Also, I am not required to inform you of my actions in this regard. These situations include but are not limited to the following: (a) If you threaten bodily harm or death to yourself or another person; (b) If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse (past or present), I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed of the court; (e) Any sexual improprieties by a former therapist must be reported to the AAMFT Ethics Committee, and (f) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different). The ethical code of licensed professional counselors prohibits dual relationships between clinician and patient and former patients. This means as my client I cannot meet with you for social occasions or be involved in any business activities with you other than providing psychotherapeutic services.

Risk to Treatment: The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, preserve personal safety, and to develop problem solving strategies to deal with current problems. Psychotherapy has both benefits and risks. Psychotherapy has been shown to produce significant improvements in emotional well-being, family and personal relationships, and work and school performance. Risks include experiencing uncomfortable levels of feelings like frustration, sadness, guilt, and loneliness. Although therapy can be a powerful life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities-exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure activities). I hope that you will see therapy through all of these phases.

Duty to Warn: In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm, including, but not limited to, the following persons, in addition to medical and law enforcement personnel:

Name	Telephone Number
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I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

Address	Telephone Number
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Appointments & Missed Appointment Policy:

Appointments: All sessions are scheduled by appointment only. Appointment times are based upon the current fee schedule. If you are filing through a health insurance carrier, please be aware that reimbursement for sessions is based on your policy and you are financially responsible for any charges not covered by the insurance company.

Set Repeated Appointments: Sometimes setting up a set weekly or biweekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically state you would like to give it up. If two set appointments are missed, I will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times.

Missed Appointments: Appointments canceled with 24 hour notice incur **no** fees and every effort will be made to reschedule in a timely manner. If you are unable to keep a scheduled appointment, please contact the office at (214) 364-4575 at least 24 hours in advance.

Appointments missed or canceled with less than 24 hour notice will be charged a \$125 cancellation fee. It cannot be billed to an insurance carrier. I understand that emergencies and health problems do come up and I am willing to consider them when adequate notice is given. However, no-shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not

be considered. Additionally, if you are billing to a third-party, the individual whose policy is being billed, must be present in order for the session to be billed. Therefore, if that individual does not attend the session that is considered a missed appointment and you will be responsible for the full fee. Please note that the provider may terminate the counseling relationship after 2 missed appointments without calling to cancel 24 hours prior to your scheduled appointment. Additionally any balance on the account for missed appointments must be paid prior to rescheduling an appointment.

Legal Proceedings: If you are currently involved or become involved with any legal proceedings, please inform me as soon as possible. It is important that we discuss how the proceedings might impact our work together. If legal actions occur in which you will be responsible to pay me for the following **even if the subpoena is sent from the opposing side of the case;** (a) the time spent for travel to/from court at the rate of \$200.00 per hour; (b) the time spent on preparing testimony, reports, witness time, and depositions at the rate of \$200.00 per hour; (c) the time spent on mediations and court appearances are billed at \$1,500 per half-day and \$3,000 per full-day.

Defamation: By signing this consent form you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others in concert with you, you further consent by signing this consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Communication:

Telephone Communication: If I am available I will respond by cell phone after hours and between sessions for non -emergencies for up to 10 minutes without charge. That number will also accept confidential voice mail messages. Phone calls over 15 minutes in length will be billed at **\$2.00 per minute**. Please note that telephone calls after 5:00 pm will not be returned until the next business day. If you find yourself facing an emergency situation, please contact emergency services (911) immediately or go to your nearest hospital emergency room.

Text Messaging: This form of communication cannot ensure confidentiality and should not be used.

Electronic Communication: When available, I will respond to email communication. However, I cannot ensure confidentiality of any correspondence sent via email and cannot be responsible for breaches in confidentiality resulting from someone getting your password or having access to your account. Therefore email communication should be reserved merely for scheduling and/or canceling

appointments. Additionally, all email correspondence between us will be printed and placed in your file. My email is **abbiesmithcounseling@gmail.com**.

Social Media: Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to gain access to the therapist's personal sites(s) will be cause for termination of therapy.

Records and Administrative Services: If you request it, any part of your record in the files can be released to any person or agency you designate. There is a **\$50 fee** to copy a client's record. Payment in the amount of **\$200** per hour will be charged for administrative services beyond the scope of the therapy sessions with a minimum of 30 minutes to complete a service. These services include but are not limited to: (a) consultation with other professionals, (b) preparation of reports or correspondence, (c) phone calls lasting over 10 minutes.

Discontinuing Treatment/Complaints: It is also important to understand that you are free to discontinue treatment at any time and agree to notify us immediately so that we may provide you with referrals for continued care. If at any time you wish to file a formal complaint regarding my counseling services, please contact the Texas State Board of Examiners of Professional Counselors and/or Texas State Board of Examiners of Marriage and Family Therapists, Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369; 1-800-942-5540. Additionally, I have the right to terminate your treatment at any time. Some of the reasons include but are not limited to: boundary violations, non-compliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided a referral source for another psychotherapy professional or agency.

Consent to Treatment:

- 1. I agree to enter into therapy with **Abbie Cottle Smith, LPC**. I have received a fee schedule and I agree to pay for services rendered with payment due at the conclusion of each session and no balance will be carried. I understand that if I am seeking reimbursement from a Third- Party Payor, I am financially responsible for all services rendered and agree to pay for claims denied by the third-party payor. I understand that if I am late to a session, the length of that session may be shortened, and I agree to pay for a full session.
- 2. I understand that I can leave therapy at any time and I have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract; I am contracting only to pay for completed therapy sessions.
- 3. A **24 hour notice** is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the **\$125.00 No-Show Fee**. I understand that this will be my responsibility not that of the third-party payor as they do not reimburse for missed appointments,
- 4. If I miss an appointment without prior notice and do not contact this office with **10 business days** following the missed appointment, then I understand my therapy will have terminated and my file will be closed.
- 5. I understand that the therapist has the right to see legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist has the right to use confidential information to establish the fee claim.
- 6. You acknowledge that you have received and understand the Notice of Privacy Practices for this office.

Signed: _____ Date: _____

Signed: _____ Date: _____

Therapist: _____ Date: _____

Therapist Supervisor: _____ Date: _____

IF A CLIENT IS A MINOR: I give permission for this minor child(ren) to receive counseling without a parent or guardian present. I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility.

Name of Child: _____ DOB: _____

Name of Child: _____ DOB: _____

Name of Child: _____ DOB: _____

Name of Parent or Legal Guardian: _____

Signed: _____ Date: _____

Therapist: _____ Date: _____

Therapist Supervisor: _____ Date: _____

2022 Fees and Payment:

Clients or Parents/Guardians are responsible for payment for all services rendered. Payment or Co-Payment is due by the end of each session. Payment may be made with cash, check, or credit card. A completed receipt will be provided at the end of each session documenting the service delivered and fees paid. Please also be aware that there is a **\$50 fee** for any returned/canceled checks and credit card charge backs/declines. My fees are as follows:

Individual Psychotherapy (50 Minutes)	\$125.00
Copying of Medical Records	\$50.00
Cancellation less than 24 hours notice	\$125.00
Admin services beyond scope of therapy sessions, with 30 minute min.	\$200/hr

Credit Card Information

Please provide your credit card information if you plan to make payments on your account or for no-shows and missed appointments without giving agreed notice:

Type of Credit Card (circle): American Express / Visa / Master Card / Discover

Name as printed on card: _____

Credit Card Number: _____

Expiration Date: _____

3-4 Digit Security Code on Back of Card: _____

Billing address for credit card:

City _____ State _____ Zip Code _____

By my signature below, I grant *Abbie Cottle Smith Counseling, PLLC* my permission to charge the account described above.

Signature/Date: _____

Printed Name: _____

By my signature below, I grant *Abbie Cottle Smith Counseling, PLLC* permission to charge the account described above for any outstanding balance that is 60 days past due.

Signature/Date: _____

All information disclosed on this form will be held in accordance with Federal Confidentiality Standards.

NOTICE OF PRIVACY PRACTICES **Abbie Cottle Smith Counseling, PLLC**

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

Abbie Cottle Smith Counseling, PLLC is required by law to abide by the terms of this *Notice of Privacy Practices*, allow you to review this *Notice* prior to granting consent, and notify you of changes/revisions to this *Notice*. If you believe your privacy rights have been violated, you may submit a written complaint to Abbie Cottle Smith Counseling, PLLC or to the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Abbie Cottle Smith Counseling, PLLC will not retaliate against you in any way for filing a complaint with him, or with the Secretary.

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your healthcare record is the physical property of Abbie Cottle Smith Counseling, PLLC, but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record. Abbie Cottle Smith Counseling, PLLC; however, has the right to use and disclose the information contained in your healthcare record in the process of providing treatment, receiving payment and performing other regular health operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers who may be involved in your case
- Educating health care professionals
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Abbie Cottle Smith Counseling, PLLC. Abbie Cottle Smith Counseling, PLLC is required by law to maintain privacy and confidentiality of your health information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you if Abbie Cottle Smith Counseling, PLLC is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice. Examples of disclosure of your PHI and your rights concerning PHI are continued below. If you have questions or would like additional information, contact Abbie Cottle Smith, the privacy officer for Abbie Cottle Smith Counseling, PLLC at 214-364-4575.

EXAMPLES OF DISCLOSURE OF YOUR PHI

Healthcare delivery and treatment: Information obtained from you by Abbie Cottle Smith Counseling, PLLC is documented in your record and used for the assessment, evaluation, diagnosis and treatment of your health conditions). This information is provided to other healthcare professionals, such as other physicians, specialists, hospital based providers and/or other healthcare providers following your treatment by Abbie Cottle Smith Counseling, PLLC. This information would only be provided to these individuals by your expressed consent, however.

Billing and Payment: Your PHI is utilized to justify the level of care delivered to you and the charged incurred for the services. This information generally accompanies the bill and is sent to our payers.

Other healthcare operations: Abbie Cottle Smith Counseling, PLLC may disclose your PHI to other individuals and businesses in order for them to perform their day-to-day operations. These other

individuals and businesses include business associates such as vendors and/or contractors used for billing and claims management. These individuals are held to the same standard of privacy and confidentiality as Abbie Cottle Smith Counseling, PLLC.

Reminders and Treatment: Abbie Cottle Smith Counseling, PLLC may contact you to provide you with information she feels is useful or helpful to you, based on your PHI. For example, she may contact you to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Abbie Cottle Smith Counseling, PLLC has already taken action in reliance on your prior authorization. The only exception to this would be under circumstances that are life-threatening or an emergency, such as an individual being acutely suicidal or in some other way in extreme danger. Not all information provided by you to Abbie Cottle Smith Counseling, PLLC will be recorded in a healthcare record, only that information considered by her to be critical to providing for your care. Other information regarding personal matters in your private life and affairs will not be made part of a healthcare record document.

YOUR RIGHTS CONCERNING PHI - Except as otherwise provided by law, you have a right to:

- receive a paper copy of this *Notice of Privacy Practices* if you have agreed to receive it electronically;
- receive a confidential communications of PHI if a request is submitted to Abbie Cottle Smith Counseling, PLLC in writing.
- inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;
- ask Abbie Cottle Smith Counseling, PLLC to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (Abbie Cottle Smith Counseling, PLLC is not required to change the information if she deems it to be accurate);
- receive an accounting of disclosures of PHI (a list of the disclosures made by Abbie Cottle Smith Counseling, PLLC about you for reasons other than treatment, payment or healthcare operations); and
- request that Abbie Cottle Smith Counseling, PLLC restrict uses or disclosures of your PHI. Though Abbie Cottle Smith Counseling, PLLC is not required to agree to a restriction, to the extent that it does agree with your request, Abbie Cottle Smith Counseling, PLLC may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

Good Faith Estimate

Under Section 2799B-6 of the Public Health Service Act, the “No Surprises Act,” you have a right to receive a “good faith estimate” explaining how much your therapy services will cost. Healthcare providers are required to provide clients who do not have insurance or who choose not to use their insurance for therapy services with an estimate of the cost of those services. If you receive a bill more than \$400 over your estimated costs, you have the right to dispute the charges. For questions or information about your rights visit www.cms.gov/nosurprises.

The amount of treatment required varies on diagnosis and length of symptoms. The following is a list of anticipated annual fees based on the psychotherapy services we provide. The annual estimated cost for weekly individual therapy sessions equals \$125 X 50 sessions (accounting for vacation and holidays) for an estimated total of \$6250. This does not include no show/late fees, after hours fees, bank charges, court/litigation fees or non-therapeutic fees.

If you end up without insurance benefits and your submitted claim is denied by the insurance company, my full rate self-pay fee is \$125. You may access www.psychologytoday.com for insurance referrals should you need to terminate and find a different in-network therapist.

Your signature indicates awareness of the Good Faith Estimate and estimated annual charges outlined in this document. Your signature acknowledges your agreement to the terms of this good faith estimate for costs and services offered at Abbie Cottle Smith Counseling, PLLC.



**ABBIE COTTLE SMITH
COUNSELING**

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RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize Abbie Cottle Smith Counseling, PLLC to disclose or receive my protected health information including: psychotherapy notes, progress notes, case notes, billing and scheduling information, assessment and psychological testing reports, physical healthcare treatment records, and psychotherapy treatment and progress.

___ School: _____

Contact person _____ Phone# _____

___ Medical Doctor: _____

Address: _____

_____ Phone # _____

___ Previous Therapist: _____

Address: _____

_____ Phone# _____

___ Insurance Company: _____

Address: _____

_____ Phone# _____

___ Other: _____

Address: _____

_____ Phone # _____

This release shall remain in effect until such time as it is revoked in writing by me.

Signature of Client/Legal Representative Date of signature

Relationship of Legal Representative Client's Date of Birth