Assis Counseling PLLC
becoming whole

Kim Tanuvasa, MA, LPC
9555 Lebanon Road #402, Frisco, TX 75035 | (469) 777-3050

CONSENT FOR TREATMENT

CLIENT RIGHTS AND RESPONSIBILITIES:
As a counselor, I am dedicated to helping individuals, couples, and families heal, grow, and change. I am pleased that you chose me to be your therapist. This document is designed to inform you about my background and qualifications as a therapist and to clarify our professional relationship as well as your rights and responsibilities.

EDUCATION:
Southern Methodist University, MA Counseling and Clinical Psychology

TREATMENT:
The therapeutic relationship is a unique professional relationship that is tailored to an individual's needs. During the first two sessions you and I will develop therapeutic goals and prospective course of treatment, which can be re-evaluated during the course of therapy. Goals may include current stressors, emotional challenges, relationships, parenting, as well as past experiences and family of origin. As a therapist, I find that past experiences and family of origin, plays a role in how people address problems in the present. We will collaborate on what needs are most relevant to your current growth.

Clients need to be aware that therapy may produce internal changes, and clients often experience a surge of intense feelings. Sometimes symptoms may worsen before they get better. Counseling is a personal exploration that may lead to major changes in your life perspective and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Together we will work to achieve the best possible results for you.

Treatment duration and frequency will vary depending on the presenting problem and client need. As a client, you have the right to end counseling relationship at any time. You also have the right to refuse or discuss modification of counseling techniques you believe are harmful.

EMERGENCIES:
In the event of an emergency, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

SOCIAL MEDIA:
Please do not send therapist invites to social media (Facebook, LinkedIn, etc.) as it risks compromising confidentiality and therapeutic boundaries.

YOUR RIGHT TO PRIVACY:
I will not share information disclosed in counseling without your written consent. However, there are limits to confidentiality that require disclosure of confidential information if the following applies:
- Abuse or neglect of a child, elderly or disabled person.
- You are threatening to harm yourself or others. I may need to contact relatives, law enforcement or appropriate authorities to safeguard you or the person(s) you are threatening.
- When insurance company or third party payer requests information to pay claims.
- There is a license board inquiry.
- If I am subpoenaed to disclose information.
- Professional consultations to provide quality care, if this occurs identifying information will not be disclosed.

FEES:
Session: If you have health insurance I accept, you are responsible for the copayment or deductible. If you are with an EAP your payment is $0 until EAP sessions are exhausted. I will file claims on your behalf and will bill for outstanding balances after 30 days of non-payment. Out-of-network cost is $130 for a 60 minute individual session and $150 for a 60 minute family or couple session**.** Sliding scale rates are offered on a limited basis. Payment is expected in full at each session.
Cancellations: There is a $50 fee for no-show and for appointments cancelled less than 24-hour. Reminders are sent as a courtesy only, and clients are responsible to cancel appointments prior to 24 hours regardless of whether they receive a reminder or not. Multiple cancellations, late cancellations and/or no-shows may result in referral to another provider.
Phone consultations: Therapist will be glad to discuss clinical concerns over the phone outside of session. Phone consultations lasting more than 10 minutes will be billed at $1 minute.
Litigation limitation: Therapist is not an expert witness. Due to the confidential nature of counseling and that it involves sensitive information, it is agreed should you be involved in legal proceedings neither your nor your attorney will call me to testify in court, nor will a disclosure of therapy records be requested. If this is something you require, I will gladly provide a referral to a more appropriate provider. If I am subpoenaed to provide testimony or records in a legal matter, you agree to pay $350/hour for preparation, travel, and attendance at legal proceedings. Payment is due 10 days prior to the court date.

I have read the preceding information and understand my rights and responsibilities as a client.

Client's 1 Signature_____ Date_____

Client's 2 Signature_____ Date_____

If minor, Guardian's Signature _____ Date_____

I authorize clinician file insurance claims with my insurance provider or third party payor for payment of services, the release of any clinical information necessary to process this claim and request payment be sent to the clinician who provided counseling and psychological services.

Signature_____ Date_____

By signing below I acknowledge I am financially responsible for current and outstanding balances. Payment is collected after each session. Uncollected fees may be referred to a collection agency.

Signature_____ Date_____

Assis Counseling PLLC
becoming whole

Kim Tanuvasa, MA, LPC
9555 Lebanon Road #402, Frisco, TX 75035 | (469) 777-3050

HIPAA PRIVACY FORM

NOTICE OF PRIVACY PRATICES

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical and psychological information about you and your health is personal, and we are committed to protecting that information. We create a record of your benefits, eligibility status, and claims history in order to provide quality health care services, as well as, comply with legal requirements. Different health care professionals may have different policies regarding their uses and disclosure of your medical information. This document is required by law to describe the ways in which we may use and disclose medical information about you as well as your rights and obligations toward your medical information. You may request a copy of this Notice at any time.

HOW WE MAY USE AND DISCLOSE INFORMATION

We use and disclose health information about you for treatment, payment, and health operations. For example:

Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. This includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Other uses of your medical information include:

Your Authorization: You may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, only when you agree we may do so.

As Required by Law: We may use or disclose your health information when required to do so by law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure would be to someone able to help prevent the threat.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to federal officials or military authorities required for lawful intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use limited health information to provide appointment reminders (such as voicemail messages, emails, text messages, postcards, letters).

YOUR PATIENT RIGHTS

To Access Your Medical Records: You have the right to look at or get copies of your health information, with limited exceptions, provided that this request is in writing. You will be charged a fee for expenses such as copies, postage, and staff time. If you prefer, we will prepare a summary or an explanation of your health information for a fee. *Under federal law, however, you may not inspect or copy psychotherapy notes or psychological evaluation information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.* In some circumstances, you may have the right to have our decision to deny you access to your medical information reviewed. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure or any questions about access to your medical information.

To Request Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

To Amend Medical Information: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 5 years. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests.

CHANGES TO THIS NOTICE

We reserve the right to change our private practices and terms of this Notice, provided such changes are permitted by applicable law. Before we make a significant change in our private practices, we will change this Notice, and make the Notice available upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policies or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights you may file a complaint to our office or the Secretary of the United States, Department of Health and Human Services. All complaints must be submitted in writing.

Kimberly Tanuvasa, M.A., LPC
9555 Lebanon Road #402
Frisco, TX 75035
469.777.3050

Texas State Board of Examiners of
Professional Counselors
100 West 49th Street
Austin, TX 78756-3183
512.834.6658

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Printed Name_____

Client Signature_____ Date_____

Client/Guardian/Parent Signature_____ Date_____

_____ Initial to acknowledge receipt of HIPAA and Consent.