COUNSELING SERVICES AGREEMENT

Counseling Fees

Private Pay

For patients not using health insurance the fee for counseling services is $125 per 55 minute session.

In Net Work Insurance

For those using in-network health insurance, session fees are based on your insurance company’s fee schedule, which varies by insurance company and your specific policy. If you have eligible in-network insurance coverage, Christian Counseling of Texas PLLC, or its billing service, Kasa Practice Solutions, will submit claims on your behalf. If you were not eligible for mental health benefits at the time of service, you are responsible for the Private Pay rate of $125. You are also personally responsible for deductibles, co-payments, co-insurance, and non-covered or ineligible services. Please call your insurance company’s customer services number to verify your coverage and ask any questions.

Out of Net Work Insurance

Patients who are covered by private commercial insurance in which Steven Kopor MA, LPC-S, LCDC, is not contracted with as a “network provider” will be required to pay the Private Pay rate of $125 at the time of service. We do not file claims with insurance companies that we are not contracted with. We will provide you with a receipt sufficient to file your own claim with your insurance company to receive reimbursement.

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read and fully understand all the information in the “Counseling Fees” section in this Counseling Services Agreement and have had my questions answered to my satisfaction. I accept, agree, understand, and consent to abide by this “Fees and Insurance” policy.

______________________________       ______________________
Patient Name (Please Print)                                                             Date

______________________________       ______________________
Signature of Patient                                                                          Date

______________________________       ______________________
Counselor’s Signature                                                                      Date
COUNSELING SERVICES AGREEMENT

Miscellaneous Fees and Payment Procedures

The following fees apply to all patients and are not covered by insurance: Reports & letters, $25. Records request, $10 dollars. Court appearances, $500 per day of appearance. Phone calls, $1 per minute after the first five minutes. There is a $20 charge on all returned checks. If Patient is ineligible at the time services are rendered, Special mailing fees will be passed on to the patient requesting the records. Attendance Policy Violations - $30.

Payments can be made by cash, personal check (made out to Christian Counseling of Texas), by credit card either by: 1) calling 817-718-7100 or 2) by going to the www.ChristianCounselingofTexas.com web page and clicking the “Make a Payment” button.

Please have your payment ready at the beginning of each session.

We may have to send you an invoice for any remaining balance. This bill represents the amount you owe Christian Counseling of Texas

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read and fully understand all the information in the “Miscellaneous Fees and Payment Procedures” section in this Counseling Services Agreement and have had my questions answered to my satisfaction. I accept, agree, understand, and consent to abide by this “Fees and Insurance” policy.

_________________________                  ______________________
Patient Name (Please Print)                       Date

_________________________                  ______________________
Signature of Patient                               Date

_________________________                  ______________________
Counselor’s Signature                             Date
COUNSELING SERVICES AGREEMENT

Attendance Policy

I view all “no show/no call” patients, cancellations with less than 24 hour advance notice, or any missed appointment, as a very serious problem and a breach of the Counseling Services Agreement. Since insurance companies do not pay for these missed appointments, patient agrees to accept financial responsibility for the missed session and pay $30 before another session is scheduled. Any patient who does not pay the $30 fee will not be rescheduled and will be discharged.

I immediately discharge all clients who "no show/no call" and fill the time slot ASAP, often immediately. Therefore, calling after a missed appointment may result in already having lost the standing appointment time. Any patient who repeatedly (more than once per quarter) cancels appointments will result in patient being discharged.

Your reservation of the scheduled session time prevents me from using this time for another patient. Missed appointments mean one thing to all counselors: lost revenue. I can’t allow those I’m trying to help to negatively effect my livelihood in this way. Even paying the $30 fee is a loss of revenue. If I allow just one person per week to miss their appointment and not collect the Missed Appointment Fee my annual income drops about $5000 per year.

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read and fully understand all the information in the “Attendance Policy” section in this Counseling Services Agreement and have had my questions answered to my satisfaction. I accept, agree, understand, and consent to abide by the Attendance Policy.

________________________________________________         ______________________
Patient Name (Please Print)                                                             Date

________________________________________________         ______________________
Signature of Patient                                                                          Date

________________________________________________         ______________________
Counselor’s Signature                                                                      Date
COUNSELING SERVICES AGREEMENT

Counseling Services

Christian Counseling of Texas PLLC, provides professional counseling from a Christian perspective to address spiritual, psychological, emotional and mental health issues. My approach is eclectic, usually focusing on identifying solvable problems, setting realistic goals, designing interventions, and examining progress and outcomes. Generally, I practice cognitive behavioral therapy and solution focused therapy, again, from a Christian perspective. Patient consents to voluntarily engage in such activities and patient understands that they may stop at any time.

Benefits and Emotional Risks

The majority of patients that obtain counseling services benefit from the experience, but some risks do exist. As counseling begins, some experience unwanted feelings, because examining old issues may produce unhappiness, anger, guilt or frustration. Important personal decisions are often an outcome of counseling. These are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed as negative by another. Don’t hesitate to discuss treatment goals, procedures, or your impressions of the services that are being provided.

Termination of Counseling

When the goals we define at the beginning of counseling are met, unless new goals are defined, the logical conclusion to counseling has arrived. Sometimes it becomes apparent that goals cannot be met. This, too, is a logical time to stop meeting. If I do not believe I can be of help, I will certainly let you know. That being said, the Patient can always stop counseling for any reason. Ideally, there would be agreement as to when it is time to stop meeting. Likewise, if I think your continuation in counseling is a medical necessity, I will tell you so and make a referral to another therapist. It is best to have a defined final session where we can review progress and establish a discharge plan.

I authorize and request that Christian Counseling of Texas PLLC, carry out screening, intake, orientation, assessment, treatment planning, professional counseling from a Christian Perspective, case management, crisis intervention, patient education, referral, reports, record keeping, and consultation, which now or during the course of my care are medically necessary and advisable. I understand that the purposes of these procedures have been explained to me and subject to my agreement. I hereby consent to voluntarily engage in such activities and I understand that I may stop at any time. I further understand that any counseling treatment may involve risk and that I am undertaking treatment at my own risk. By signing this consent for treatment, Patient acknowledges that he or she has read this document and understands it.

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read and fully understand all the information stated in the “Counseling Services,” “Benefits and Emotional Risks,” and “Termination of Counseling” section in this Counseling Services Agreement and have had my questions answered to my satisfaction. I accept, agree, understand, and consent to abide by these policies.

Patient Name (Please Print)                  Date

________________________________________
Signature of Patient                                      Date

________________________________________
Counselor’s Signature                                 Date
COUNSELING SERVICES AGREEMENT

Limits of Confidentiality
The content of counseling sessions is private and protected by law except in cases of suspected abuse or neglect of children, the elderly or disabled. It is the law that I report all suspected abuse or neglect, on children, the elderly, or the disabled to the authorities. Another exception to privacy would be when a Patient intends dangerous or criminal harm to self or others. Patient's written authorization can release Protected Health Information to any entity.

Release of Protected Health Information
Patient hereby authorizes the release of Protected Health Information to their health plan, Kasa Practice Solutions, or any other payor for the payment of counseling sessions, pre-authorizations, certification, case management decisions, and other purposes related to the administration of treatment.

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read the “Limits of Confidentiality,” and “Release of Protected Health Information,” information provided above. I also acknowledge that I have received a copy of Christian Counseling of Texas’ “Notice of Policies and Practices to Protect the Privacy of your Health Information,” I have read all this information, understood it and have been given the opportunity to ask any questions I may have regarding HIPAA and this Counseling Services Agreement page. I fully understand all the information in this Counseling Services Agreement page.

________________________________________________         ______________________
Patient Name (Please Print)                                                             Date

________________________________________________         ______________________
Signature of Patient                                                                          Date

________________________________________________         ______________________
Counselor’s Signature                                                                      Date
COUNSELING SERVICES AGREEMENT

Emergency Procedures

I DO NOT provide crisis counseling by phone, text, email, faxes or internet in between the regularly scheduled session times. In case of a mental health emergency, Patient should call 911, or go to the nearest emergency room. If Patient calls to ascertain whether it is necessary to go to the hospital and/or call 911, Christian Counseling of Texas PLLC, will always say yes.

Telephone Counseling

Christian Counseling of Texas PLLC, does not do telephone counseling. Phone calls are reserved for emergencies and scheduling.

Recordings

There will be no recording of our meetings or any phone conversations. All of our discussions are private and confidential.

Social Media

I do not accept “friend” or “contact requests” from current or former clients on any social networking site. Additionally, if we run into each other in the community, I will not acknowledge you to protect your confidentiality.

By signing this Counseling Services Agreement page, I hereby acknowledge that I have read, understood all the terms, and satisfactorily had all my questions answered on “Emergency Procedures,” and “Telephone Counseling,” “Recordings” and “Social Media sections in this Counseling Services Agreement.

___________________________     ______________________
Patient Name (Please Print)                             Date

___________________________     ______________________
Signature of Patient                             Date

___________________________     ______________________
Counselor’s Signature                             Date
Current Symptom Checklist (Rate intensity of symptoms currently present)

- **Mild** = impacts quality of life, but no significant impairment of day-to-day functioning
- **Moderate** = Significant impact on quality of life and/or day-to-day functioning
- **Severe** = Profound impact on quality of life and/or day-to-day functioning

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Impact</th>
<th>Symptom</th>
<th>Impact</th>
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<tbody>
<tr>
<td></td>
<td>None</td>
<td>Hyperactivity</td>
<td></td>
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<tr>
<td>Drug Use</td>
<td></td>
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<tr>
<td>Irritability</td>
<td></td>
<td>Aggressive Behaviors</td>
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<tr>
<td>Alcohol Use</td>
<td></td>
<td>Trust Issues</td>
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<tr>
<td>Adultery</td>
<td></td>
<td>Selfishness</td>
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<tr>
<td>Anorexia/Binging/Purging</td>
<td></td>
<td>Mood Swings</td>
<td></td>
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<tr>
<td>Spiritual Problems</td>
<td></td>
<td>Obsessions/Compulsions</td>
<td></td>
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<tr>
<td>Assaults Others</td>
<td></td>
<td>Often Sad</td>
<td></td>
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<tr>
<td>Sleep Disturbance</td>
<td></td>
<td>Agitation</td>
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<tr>
<td>High Stress</td>
<td></td>
<td>Panic Attacks</td>
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<tr>
<td>Nightmares</td>
<td></td>
<td>Paranoia</td>
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<tr>
<td>Conduct Problems</td>
<td></td>
<td>Suicide Issues</td>
<td></td>
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<tr>
<td>Delusions</td>
<td></td>
<td>Physical Trauma Perpetrator</td>
<td></td>
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<tr>
<td>Depressed Mood</td>
<td></td>
<td>Domestic Violence</td>
<td></td>
</tr>
<tr>
<td>Dissociative States</td>
<td></td>
<td>Self Esteem Issues</td>
<td></td>
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<tr>
<td>Poor Concentration</td>
<td></td>
<td>Poor Grooming</td>
<td></td>
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<tr>
<td>Elevated Mood</td>
<td></td>
<td>Emotional Affairs</td>
<td></td>
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<tr>
<td>Marriage Problems</td>
<td></td>
<td>Self-Injurious Threats</td>
<td></td>
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<tr>
<td>Emotional Trauma Perpetrator</td>
<td></td>
<td>Self-Mutilation</td>
<td></td>
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<tr>
<td>Emotional Trauma Victim</td>
<td></td>
<td>Sexual Problems</td>
<td></td>
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<tr>
<td>Emotionality</td>
<td></td>
<td>Co-dependency</td>
<td></td>
</tr>
<tr>
<td>Fatigue/Low Energy</td>
<td></td>
<td>Sexual Abuse Victim</td>
<td></td>
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<tr>
<td>Frequently Tearful</td>
<td></td>
<td>Significant Weight Gain/Loss</td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
<td>Phobias</td>
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<tr>
<td>Grief</td>
<td></td>
<td>Social Isolation</td>
<td></td>
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<tr>
<td>Guilt</td>
<td></td>
<td>Body Pain</td>
<td></td>
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<tr>
<td>Hallucinations</td>
<td></td>
<td>Substance Abuse</td>
<td></td>
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<tr>
<td>Hopelessness</td>
<td></td>
<td>Worthlessness</td>
<td></td>
</tr>
<tr>
<td>Hostile Angry Mood</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
Name _____________________________________   DOB ____________   Today’s Date ________________

Describe prior outpatient counseling    □ None
Include provider’s name, what you were seeing them for, approximate number of sessions, and if it was beneficial.
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Describe prior inpatient treatment for a psychiatric, emotional or substance abuse disorder.    □ None
Include as much information as possible. Please bring discharge documents.
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
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Describe prior or current psychotropic medication use    □ None
Include medication and dosages; approximate start date.
_____________________________________________________________________________________________________
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Describe prior suicide attempts or just thinking about it    □ None
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Describe current suicidal thinking (recent 6 months)    □ None
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
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State your reasons for counseling
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Page 8 of 8
NOTICE OF POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This Notice Describes How Psychological and Medical Information about You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it Carefully.

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your therapist or one of the office's employees.

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

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways we are committed to use and disclose your "PHI" will fit within one of these general categories:

For Treatment, "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 counselor.

For Payment, "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. We may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.

For Healthcare Operations, "Healthcare Operations" are activities that are related to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. We may use and disclose health information to you with appointment information. This may be done with voicemail, messages, postcards, and other mailings.

Use, "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure, “Disclosure” applies to activities outside of our office 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, or 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 or 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. 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 reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

Adult and Domestic Abuse. If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.

Health Oversight Activities. If we receive a subpoena or other lawful request, we must disclose the relevant PHI pursuant to that subpoena or lawful request.

Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.

Law Enforcement. We may release PHI about you if required by law when asked to do so by a law enforcement official.
Serious Threat to Health or Safety. If you communicate to us a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.

Worker’s Compensation. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient’s Rights and Counselor’s Duties

You have the following rights regarding the PHI that this office maintains about you.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. 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 our office. On your request, we will send your bills to another address.) To request confidential communications, you must complete a request in writing and submit it to the Counselor. We will accommodate all reasonable requests.

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must request it in writing and submit it to the Counselor. If you request copies, we will charge you $0.10 per page. We may deny your access to PHI 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. To request an amendment, you must request it in writing and submit it to the Counselor. In addition, you must provide a reason that supports your request. 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. On your request, we will discuss with you the details of the accounting process. To request this accounting on disclosures, you must request it in writing and submit it to the Counselor.

Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from us upon request.

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 we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, or you believe that your privacy rights have been violated and wish to file a complaint with us/our office you may contact Steven Kopor LPC-S at 817-718-7100, or send your written complaint to Christian Counseling Professionals, 6040 Camp Bowie Blvd., Suite 65, Ft. Worth, TX 76116. 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. You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2015. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice in our office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.