SPIRIT CHRISTIAN COUNSELING CENTERS

3550 Parkwood Blvd, Building D, Suite 401
Frisco, Texas 75034
469-660-8620

COUNSELING SERVICES AREEMENT
And INFORMED CONSENT

Welcome.

We look forward to working with you regarding the concerns that brought you here. If you have any questions regarding our professional services or policies, please discuss them with your therapist. Your therapist will verbally review this information in your initial meeting. Your signature at the end of this document indicates you have read and understand the information, and have asked any questions necessary to clarify your understanding, thus providing an agreement for proceeding with treatment.

How did you find us? (Please circle and be specific)

FRIEND REFERRAL INTERNET PSYCHOLOGY TODAY OTHER______

Who We Are

Spirit Christian Counseling Centers are committed to providing faith based counseling in a comfortable, confidential atmosphere with Christian counselors who practice clinical therapeutic skills within a biblical framework. Our overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. We believe all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus we are committed to providing quality psychological care to assist individuals, their families, and the community at large, in achieving these goals. Each therapist employs a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction.

The Counseling Experience

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well- being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges.

In the counseling process, you will develop the goals for your counseling. Any changes or decisions that you desire to attain well ultimately rest on you. As such, psychotherapy requires your active participation in identifying problems and goals, and depends on many factors including motivation, effort to make changes, and how well you work with your therapist as a team. For this reason the counselors at Spirit Christian Counseling Centers do not guarantee any specific result during the therapy or counseling goals. Your therapist will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. Your therapist will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, resolution or peace in faith issues, solutions to specific problems, and significant reduction in feelings of distress. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, your therapist will anticipate these risks and discuss them with you throughout the course of therapy. Your therapist is committed to working with you to achieve the best possible results for you.

Therapy Length: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Please understand that as a client, you have the right for the counseling relationship to last as long or as short as you desire. Your first 1-3 sessions will involve an evaluation of your needs and goals. Your therapist will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with your therapist are crucial to your success in therapy. Understand that the more active you are in the therapeutic process, the easier it will be to attain your goals. If you have any questions about the process at any time please feel free to ask for explanation.

Sessions are usually 45-50 minutes in length, and are initially scheduled on a weekly basis. More frequent sessions are available for crisis situations, less frequent sessions are scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy.

Therapy Relationship: While psychotherapy often addresses very personal issues, for your work to be therapeutic the relationship between you and your therapist must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with your therapist will be limited to sessions you schedule at our office. In order to maintain a professional ethical relationship with clients, counselors insist that you not offer them gifts, request them to write references, ask them to attend social outings, or communicate to you in any other way than the professional context in the counseling relationship. Your therapist will not accept friend requests on social networking sites.

Privacy – Trust and openness are essential for effective therapy, therefore confidentiality is of the utmost importance where the client-therapist relationship is concerned. In order to protect client confidentiality we at Spirit Christian Counseling Centers adhere to the following procedures:

1. Written, electronic, telephone, or personal inquiries about clients will not be acknowledged without permission. You must sign a release before any information about you is given to anyone outside the counseling center. Even then we may advise you to withhold information if we feel it is in your best interest.
2. All records and identifying materials are kept confidential.
3. Records are destroyed on a regular basis after 5 years as provided for in Texas law.
4. Non-identifying Information regarding your case is only shared with other licensed professionals in cases of supervision and peer consultation in order to enhance the services you receive. The personnel in our office who may need to access your file for administrative purposes are also bound by confidentiality.

Any other disclosure of the information in your medical records must be named by a written authorization from you, the client. Upon each request, an individual form will be filled out for release of information. Please understand that you may revoke any authorization in writing unless the information is already released to the other party

Therapy Cancellation: At any time during the therapeutic process you have the right to discontinue your professional relationship with your therapist, or request a referral to another therapist; though it is recommended you schedule a termination session for reaching closure. During any point during the therapeutic process your Counselor also has the right of referring individuals to another therapist whom they feel might be more qualified to handle the client's situation. You also have the right to refuse any recommendations your therapist makes. If your refusal compromises your therapist's ability to render services in an ethical or beneficial manner (for example: refusal to make a safety contract when feeling suicidal), your therapist may choose to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire. You will be responsible for contacting and evaluating those referrals/ treatment alternatives. Not following-up with provided referrals will be understood as your unspoken request to terminate therapy and treatment.

Referral or Transfer of Treatment - If the provider believes that continued treatment is no longer providing the me value, or the therapist must move out of the area to a location that makes continued treatment impossible in accordance with state law, he/she may terminate treatment or provide referral name(s) for other therapists, even if I do not agree. If I choose not to seek out treatment with the therapists referred or another therapist of my choosing, my actions will represent my unspoken request to terminate treatment.

Transfer of Records Policy: In the case of death or incapacity, the therapists in this office have made provision for another mental health provider to take possession of all patient records. In this event, you may contact Jeffrey K. Fletcher, LPC-S, LSOTP at 972-322-5050 for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing. Mr. Fletcher does not have a copy of your record, and only has access to records in the case of death or incapacity. Please make ALL regular business requests for records and/or copies through the Spirit Counseling Center offices.

Communication Policy - Calls, emails, or texts placed to, or from Spirit Christian Counseling Center offices will be primarily for the purpose of scheduling or rescheduling appointments. Be aware that information sent via email or text are not guaranteed to be secure or confidential. For your protection, we advise that you limit your email and texts to dealing with typical office matters such as scheduling or billing questions. All other matters should be discussed during your session time.

Emails are checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information.

After Hours Communication - When calling the center after hours, or when there is no answer, we ask that you leave a message. **Spirit Christian Counseling Center is NOT an emergency facility.** Except by prior agreement, communications placed to the counseling center office on weekends or after hours will be returned within 24 hours of the next business day. (Communications placed Friday through Sunday are returned by the following Tuesday)

Network communication formats (email, texts, etc.) are not intended for crisis communications, clinical purposes, or as replacements for therapy. If you have an urgent concern contact your therapist to schedule a therapy session and discuss the concern in session. If you have an emergency*, and cannot contact your therapist, call 911 and/or go to the nearest emergency room.

> *(Emergency situations are those in which someone experiences potentially life threatening symptoms, believes they have lost control of their behavior, is hearing voices or seeing things that are not present, has ideas or plans of harming themselves or others, or demonstrates potentially harmful behavior).

Crisis management calls to the center or a therapist will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. Any phone call lasting more than 10 minutes will be charged per minute at your regular session rate. For example: if your regular session fee is $100/per session, a call lasting 15 minutes will be charged $25.00.*

Appointment cancellation: When cancellation of a counseling session is unavoidable, it is important for the client to notify the counselor 24 hours in advance of the appointment time to avoid being charged for the full session. Consistently missed appointments (barring bona fide emergencies) or failure to complete counseling homework assignments on a regular basis may result in termination of the counseling relationship.

Late Arrivals Policy: If a counselor is late to the session, the session time can be extended to allow the client full session time. If the client is late to the session, it is accepted as the client's implicit choice to use the time as he/she sees fit, and the session will not be extended beyond the scheduled end time.

Fees and Payment Policy - Dr. Luigi Leos charges $130 per 50 minute-hour for individual sessions, $150 per 50 minute-hour for family/marriage sessions. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. If payment becomes a hardship for you, please discuss this with your therapist so a suitable payment plan can be arranged for you. At this time, no one in our office accepts insurance as a form of payment. You are fully responsible for all sessions. If you have questions regarding your account balance, you may call the center and speak with your provider. Therapy sessions may be unavailable if the account is not in good financial standing.
If you wish, you will be provided with a receipt for services that can be submitted to an insurance carrier for out-of-network reimbursement. **You should be aware that some insurance plans do not reimburse for marital/family therapy or out of network services.**

Other Services for Which Additional Fees May Apply include: telephone calls, clinical consultations with other providers that you give consent for your therapist to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies. **For legal proceedings that require your therapist's response, we bill $600 per hour** (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). **Payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Licensure: The Clinic Director, Dr. Luigi Leos, is experienced in a variety of approaches to therapy, including Cognitive Behavioral Therapy, Experiential, Family Systems, Family of Origin, and Emotion Focused Couple's Therapy. He is also an associate university professor and teaches counseling courses on a graduate school level. Dr. Leos holds a Doctor of Philosophy degree in Psychology, and Master of Arts degrees in Marriage and Family Counseling, Christian Education, and Organizational Behavior. Dr. Leos is licensed by the Texas State Board of Professional Counselors (License Number 63241), and the Colorado State Board of Marriage and Family Therapist Examiners, (License number MFT.00001656).

Policy on Treatment of Protected Health Information (PHI) and Confidentiality of Client Records -
"Protected Health Information" (PHI) is information about you (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Our communications over the course of therapy become part of your **protected health information** as does information about you is generated as receipts and notes that record your contacts, visits, and payments for healthcare services. For more information see the Appendix: "Notice on Protected Health Information (PHI) and Patient Rights" section at the end of this document.

Complaints: Our services are rendered in a professional manner consistent with the legal and ethical standards established by one or more of the following:
Texas State Board of Examiners of Professional Counselors 512-834-6658
Colorado State Board of Marriage and Family Therapist Examiners:
https://dpo.colorado.gov/FileComplaint

If at any time or for any reason you are dissatisfied with our services, please let your therapist know. If your therapist is not able to resolve your concerns to your satisfaction, you may contact the Clinic Director, Dr. Luigi Leos at 469- 660-8620. If you are still unsatisfied, you may report your complaints to

Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street Austin, Texas 78756 at 1-800-942-5540. (Services are available to the hearing and speech impaired through Relay Texas: 1-800-735-2989.
Or,
Colorado Department of Regulatory Agencies, Division of Professions and Occupations, 1560 Broadway,Suite 1350, Denver, CO 80202.

Treatment Agreement

Name of person to be seen in session: ____

In signing this form I affirm, consent, and agree that: (Please Initial Each)

_____ 1. I have read this document carefully and understand the information described herein – especially regarding: characteristics of therapeutic treatment, personal health information, confidentiality of my mental health records, Spirit Christian Counseling Center communication, fee policies, and PHI information.

______ 2. I understand that counseling may involve discussing relationship, spiritual, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am aware that there are alternative treatment facilities available to me and that I am free to not participate in any treatment that I am uncomfortable with for any reason.

______ 3. I understand that my role as a client is:

a. To be honest during counseling sessions, complete homework assignments, and demonstrate a willingness to change.
b. To refrain from the use of alcohol or drugs prior to a counseling session.
c. To pay counseling fees at the time of service.

______ 4. I understand that I may terminate treatment at any time, although I have been informed that this is best accomplished in consultation with the therapist.

______ 5. I understand that if my provider believes that continued treatment is no longer providing me value, or must move to a location that makes continued treatment impossible in accordance with state law, he/she may terminate treatment or provide referral name(s) for another therapist, even if I do not agree. I do agree that it will be up to me to follow-up with referral names that I have been provided, and my not acting to seek out and contract with a new therapist should be understood as my unspoken request to terminate treatment.

______ 6. I affirm that not attending two or more consecutive sessions is to be considered my unspoken request to end treatment.

______ 7. I understand and agree to the services at Spirit Christian Counseling Center being provided by doctoral or master's level therapist.

______ 8. I understand that my therapist will consult with peer or supervising therapists, employed by or independent of Spirit Christian Counseling Centers, regarding my case in order to improve the quality of my treatment.

______ 9. I understand any information shared in supervision or peer consultation sessions will not include specific identifying information, and that consultants and supervisors will be under the same confidentiality restrictions as Spirit Christian Counseling Centers.

______10. I understand services can include case consultation by phone or in person with my primary care physician, attending psychiatrist, and/or previous therapists named on a release of information form signed by me, and that the release can be revoked by me at any time for any reason.

______11. I affirm that I have read and understand the limits of confidentiality in therapy and that I have signed and been provided a copy of a Limitations of Client-Therapist Confidentiality form describing those limits.

______12. I understand that, should I require services when my therapist is on vacation, this consent is transferable to the covering professional as designated by my therapist. I agree to work with the designated therapist if I cannot wait until my therapist's return, or in an emergency, I will call 911 and go to the nearest emergency room.

______13. I agree and consent to / or decline (Circle One) the use of non-encrypted email and texts to communicate with Spirit Christian Counseling Center staff primarily for the purpose of scheduling or rescheduling appointments. I understand that I have the right to not use of email and/or texting mediums and limit scheduling communications to conversations and voice mail via telephone.

______14. I understand that internet communication formats (email, texts, etc.) are not intended for crisis communications, clinical purposes, or as replacements for therapy. I agree that if I have an urgent concern, I will contact my therapist to schedule a therapy session and discuss the concern in session; and If I have an emergency, and cannot contact my therapist, I will call 911 and/or go to the nearest emergency room.

______15. I understand that internet communication formats (like email and texting) are not encrypted or secure and can be viewed by unintended persons. I release and hold harmless Spirit Christian Counseling Center for any claim(s) I may have, past, present, and future, arising from the use of electronic communications, including but not limited to email and texts, to communicate with me.

______16. My therapist has satisfactorily answered all of my questions about counseling at Spirit Christian Counseling Centers. I understand if I have any additional questions that my therapist will either answer them or find answers for me, and if they are not answered to my satisfaction my questions may be addressed to Dr. Luigi Leos, Clinical Director, of Spirit Christian Counseling Center at 469-660-8620.

______17. I have been furnished with a paper or electronic copy of this signed document.

I hereby give my consent for psychological treatment for Myself / My Child (Circle one or both).
from Luigi Leos, Ph.D., LPC (TX), LMFT (CO), with Spirit Christian Counseling Centers and agree to comply with the policies stated in this document.

Client/Guardian Signature _________________ Witness Signature _________________

Client/Guardian Name ____________________ Witness Name ____________________

Payment Agreement: _____________ Date _____________

APPENDIX:
Notice on Use of Protected Health Information (PHI) And Patient Rights

This notice describes your (the patient's) rights to access and control your protected health information (PHI). It also describes how PHI is used or disclosed to provide for treatment or payment for healthcare services, and to manage health care operations.

"Protected Health Information" (PHI) is information about you (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Our communications over the course of therapy become part of your **protected health information.** Other protected health information about you is generated as receipts and notes that record your contacts, visits, and payments.

How We (The Provider) May Use or Disclose Protected Health Information (PHI)

Following are examples of use and disclosures of your protected health care information that we (the provider) are permitted or required to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

To others Involved in Your Healthcare - Unless you object, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that you identify as responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.
For Legal Proceedings - We may disclose protected health information in the course of any judicial or

administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Your (The Patient's) Rights Regarding Disclosure of Protected Health Information

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize, deny, or revoke any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request. Fees associated with copy services are listed in the Fees and Payment policy.

You may have the right to have us amend your protected health information for accuracy and completeness - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

Complaints regarding PHA Violations

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. For information about HIPPA or to file formal complaints you must make a written compliant within 180 days of violations. You may file a complaint with us by notifying our Privacy Manager of your complaint or by contacting:

The US Department of Health and Human services
Office of Civil Rights
200 Independence Ave. SW
Washington, D.C 20201
877.696.6775