BRIDGES OF HOPE

A Place To Find Healing And Recovery

Disclosure Statement & Informed Consent

Jodell Powers, M.A. LPC

7131Colleyville Blvd. Suite 102 Colleyville, TX 76034

(682) 233-3348 / jpowers@bridgesofhope.net

www.BridgesofHope.net

Congratulations! You have just taken the first step towards change and healing. Whatever the reason may be that you are here, I am happy to join you in your journey. Please take the time to thoroughly read and understand the following important information so that we may have a mutual understanding from the outset of our relationship. Please let me know if you have questions or concerns.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. For the same professional reason, your Therapist will decline any type of association through social media and can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade or barter for services.

AVAILABLE SERVICES: I offer a wide array of counseling services, including individual, family, couples, and group services. Effective counseling is founded on a mutual understanding and good rapport between client and Therapist. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling.

COUNSELING: I provide counseling services designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which we will determine your concerns, and if both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you

choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Jodell Powers, LPC is to provide the most effective therapeutic experience available to you. Jodell Powers renders counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with her services, please discuss this matter with her to determine if transferring to a more suitable Therapist is right for you. If you and I decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my clients an integrated solution for their mind, body, spirit, and life in order to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. If you must cancel or reschedule your appointment, I ask that you call my office at (682) 233-3348 at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Appointments not cancelled within 24 hours will result in the regular session fee and must be paid prior to rescheduling.

FEE SCHEDULE: Sessions are typically 50 minutes long. Together, the client and counselor will make decisions concerning how often and for how long they should meet. Payment is due in full at each session and either personal checks or credit/debit cards are accepted.

FEE:

Diagnostic & Evaluation Session (1st visit)	$140.00
Regular Office Visit (50 minutes – Individual or Couple)	$140.00
Outside Office Work (including but not limited to: inpatient visits, court, collaborative law services)	$350.00/hour
Written Reports (supervisors, compliance officers, etc)	$150.00/hour
Returned Check Fee	$40.00/per check

A fee of $25.00 flat rate for up to 25 pages and any additional $1 per page thereafter will be charged for copies of any records requested by the client. Only full files will be provided, no partial files will be provided.

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. I do not accept insurance, however if requested, I will provide you with a monthly receipt for filing insurance.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact my office regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, feel free to leave a message on voicemail for me. I will return your call by the end of the next business day, if not sooner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help, or call a suicide hotline: 1-800-SUICIDE. It is the client's responsibility to seek the appropriate resource in emergency situations. When I am out of town, you will be advised and given the name of another Therapist.

CONFIDENTIALITY: As a licensed Therapist, I follow all ethical standards prescribed by state and federal law. I am required to practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices available in our office.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse or neglect; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of the party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention when we discuss this matter. By signing this Information and Consent Form, you are giving consent to me as a Therapist to share confidential information with all persons mandated by law. You are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

Bridges Of Hope Therapists all work as a team for the benefit of your health and healing. As a team, we may, from time to time, discuss and exchange information with each other about you and your family. In order to provide the best guidance and support to you and your family, as well as, scheduling and payment information. Information exchanges between the members of the team will not be disclosed to other nonaffiliated therapists outside of the practice, unless a written release has been signed by the client.

When Jodell Powers works with children and adolescents between the ages of 12-17 years, she uses her professional judgment to ascertain what information will be kept confidential between the child and herself, and what information is appropriate to share with the parents/guardians. Nevertheless, parents/

guardians do have the right to general information, including how therapy is going and dates of services. Keep in mind that the therapeutic process may be more successful if your child(ren) know(s) that his/her/their sessions are going to be, for the most part, confidential.

When Jodell Powers works with families, the confidentiality rules become more complicated. In the interest of the therapeutic and healing process, we encourage open disclosure between family members and couples. If a spouse/partner tells the therapist something that may harm the other partner/spouse, or a family member, or may impede the progress of the therapeutic process, the therapist will discuss this with the client, and encourage him/her to disclose it, and cannot promise to keep it confidential. At the beginning of family therapy, those members designated by the therapist and the family will sign a release form to be made part of the therapy record.

If you and your spouse/partner have a custody dispute, or a custody court hearing is scheduled in the future, Jodell Powers will need to know about it. Her professional ethics prevent her from conducting therapy and custody evaluations.

Because discussions between you and your Therapist—and even the fact that you are in counseling—are confidential, if Jodell Powers sees you in public, she will protect your confidentiality by greeting you ***only*** if you greet her first.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another Licensed Mental Health Professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another Therapist of my choosing.

COMPLAINT PROCEDURES: If you are dissatisfied with any aspect of our work together, please inform me immediately. If you feel that you have been treated unethically, by me or any other

professional in my field, and you are not comfortable resolving the conflict with me, you can contact the Texas Board of Examiners for Licensed Professional Counselors:

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
or call 1-800-942-5540 to request the appropriate form or obtain more information.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read , understand, and agree to the terms and conditions contained in the Information, and Client Consent form. I have been given the appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, I will not render services to your child until I have received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Signature - Therapist Date

_____Jodell Powers, M.A., LPC_____ _____

Printed Name Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Parent Date

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INTAKE SHEET

COUNSELEE INFORMATION

Date: _____ Referred By: _____

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Home Phone _____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____ Gender _____

Occupation _____

May we call you at your home? _____ Yes _____ No
May we call you at your office? _____ Yes _____ No
May we call you on your cell? _____ Yes _____ No
May we leave a message at your home? _____ Office? _____ Cell? _____
May we correspond via text messages through your cell phone service? _____

Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced
___ Separated ___ Widowed

Name of Spouse (if applicable) or Parents (if client is a minor)_____

Date of Marriage _____

Name of other family members:

_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____

Your Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____
___ Other

Spouse's Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____
___ Other

Previous Marital History (if applicable):
SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL INFORMATION

Are you currently attending a church? ____ Yes ____ No
If yes, what is the name of the church? _____
What is the denomination of the church? _____
Are religious or spiritual issues important in your life? ____ Yes ____ No
Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No
If yes, what are they? _____
Would you like prayer as part of your counseling? ____ Yes ____ No
How would you rate your health? _____
How many hours do you sleep each night? _____
How would you rate your diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions
___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: _____
Has your appetite or weight changed lately? _____
Are you currently on medication? ____ Yes ____ No
If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience.
_____
_____
_____
How much are you troubled by this?
____ Constantly ____ Often ____ Somewhat ____ Not Very Much
Comments concerning this problem: _____
_____
_____
Are you currently seeing another mental health professional?
(Names & Dates) _____
Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
3. Who was the counselor? _____
   What was the problem? _____

How many sessions over what period of time? _____
What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2. I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3. No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4. I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5. Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6. I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7. I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8. I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9. I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10. I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11. I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12. God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13. I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14. Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15. I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16. People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17. I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18. Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19. I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20. I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Sexual problems	____
Loss of energy	____	Self-mutilation, cutting	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	Work or school related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____
Address _____
Home Phone _____ Cell Phone _____

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the time of each appointment. I agree to be responsible for the full payment of fees for services rendered,

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

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HIPPA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This is your Heath Information Privacy notice from Bridges of Hope. This notice describes how we protect the Personal Heath Information we have about you which relates to you and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your past, present, or future mental health, treatment or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (“**HIPPA**”). We are required by law to:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of my legal duties and privacy practices with respect to your Personal Health Information; and
- Follow the terms of this notice.

We protect your Personal Health Information from inappropriate use or disclosure. Our therapist and/or employees are required to comply with these requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information ONLY when there is an appropriate reason to do so.

We will not disclose your Personal Health Information to any other company for their use in marketing their products to you.

The main reasons for which we may use and may disclose your Personal Health Information are:

- **For Payment:** We may use and disclose Personal Health Information to pay for process of your payment.
- **For Health Care Operations:** We may also use and disclose Personal Health Information at your request for your insurance needs.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone’s health or safety.
- **To Connect You with Services:** We may use Personal Health Information to provide you with information about services that may be of interest to you.

- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as a Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit, divorce or a dispute, We will release your Personal Health Information at your request. Please note per your signed Informed Consent, you have agreed not to involve Bridge of Hope or your therapist in any current or future arbitration, mediation, and/or litigation within the court system.

- **Other Uses of Personal Health Information:** Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing at any time, except to the extent that we have taken action relying on the authorization. You should understand that we will not take back any disclosures we have already made with authorization.

- **Cost of Processing Personal Health Information Request:** Due to the cost of preparing and transmitting requested Personal Health Information, we will charge $25 flat fee for up to 25 pages and an additional $1 per page thereafter.

In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you.

- **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. We may deny your request if you ask us to amend Personal Health Information that:

    - Is accurate and complete;

    - Was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;

    - Is not part of the Personal Health Information kept by or for us, or

    - Is not part of the Personal Health Information which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will NOT include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel, or made pursuant to your authorization or made directly to you. You must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail.

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

- **Changes to This Notice:** We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future.

Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available by request from us. You may also obtain a copy of the notice at our website.

I have read and understand my Rights to Privacy & Disclosure as outline in this Notice.

_____ _____

SIGNATURE DATE

_____

PRINTED NAME