JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

Client Name: _____ **DOB:** _____

Parent (if child): _____ **If Tricare, Sponsor #:** _____
social security

FOR OFFICE USE ONLY

		☐	**Copy of ID**
		☐	**Copy of insurance**
		☐	**Benefits Information**
*Tricare		☐	**Coordination of Services**
*Tricare		☐	**Release of PHI on file**
*Other		☐	**Release of PHI on file; to** Bring child to on Apt

1. _____
2. _____
3. _____
4. _____

*Only on child		☐	**Divorce Papers (if parents are divorced)** + Contact info
		☐	**IEP/Education copies** 504 OR IEP
		☐	**Other testing information** Psychologist Psychiatrist or inpatient records

INDIVIDUAL PACKET
ADULT AND CHILD

- IF Biological parents are divorced, a copy of the most current order must be provided to our office with applicable contact information for the other parent.
- IF child recieves special education support or accomodations please provide a copy

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

Today's Date: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Client's Name: _____ DOB: _____ Age: _____ Gender: ☐ Female ☐ Male
Address: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Spouse's Name (if applicable): _____
Ethnicity: ☐ Asian/Pacific Islander ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other _____
Client's Employer: _____ Occupation: _____ ☐ Not Employed ☐ Student
Spouse's Employer _____ Occupation: _____ ☐ Not Employed ☐ Student
If there is an emergency at the office and we must cancel your appointment, where should we call?
☐ Home ☐ Cell ☐ Work ☐ Email ☐ Other _____

Marital Status (more than one answer may apply)
☐ Single ☐ Legally married-Length of time: _____ ☐ Unmarried, living together-Length of time: _____
☐ Divorced-Length of time: _____ ☐ Separated-Length of time: _____ ☐ Widowed-Length of time: _____

Assessment of current relationship (if applicable): _____ Good _____ Fair _____ Poor

Please list all who live in the home:

Name	Age	Relation

Individual financially responsible for account: _____ Phone # _____
Primary Insurance Company: _____ Sponsor #/Insurance ID #: _____ Group # _____
Sponsor/Insured Name: _____ DOB: _____ Relation to Patient: _____
Was referred by: _____ Phone #: _____

Primary reason(s) for seeking services: _____

How would you rate the intensity of the problem(s) or concern(s) that brought you in? (Circle number):
1 2 3 4 5
Not Intense Moderately Intense Extremely Intense

Approximately, how long have you had the current problem? _____
In what ways have you attempted to cope with this problem? _____

CLIENTS PHYSICAL AND MENTAL HEALTH HISTORY-CLIENT NAME: _____

Primary care physician: _____ When was the last physical? _____

Any concerns shared by the doctor? _____

Physical disability: ☐ Yes ☐ No If yes, explain: _____

Have you even been hospitalized for any medical reasons? ☐ Yes ☐ No If yes, please describe _____

_____

List all diagnosis you have received from a medical professional and any other medical conditions you have or had in the past: 1_____ 2_____ 3_____ 4_____

5_____ 6_____ 7_____ 8_____

Are you under the care of a Psychiatrist? ☐ Yes ☐ No If yes, whom? _____

Have you ever been under the care of a Psychiatrist in the past? ☐ Yes ☐ No If yes, whom? _____

Do you have a mental health diagnosis? ☐ Yes ☐ No If yes, which one? _____, _____, _____

Have you been prescribed any psychotropic drugs by your Psychiatrist? ☐ Yes ☐ No

List all medications or drugs (legal or illegal) you have taken in the last year, including over-the-counter and nutritional supplements: 1_____ 2_____ 3_____

4_____ 5_____ 6_____

History of health/physical problems includes (check all that apply):

☐ Asthma	☐ Developmental Delays	☐ Major illness	☐ Shortness of breath
☐ Bedwetting	☐ Disability	☐ Nervous stomach	☐ Sleep problems
☐ Bone/joint muscle	☐ Dizziness	☐ Neurological problems/exam	☐ Surgeries
☐ Chest pain	☐ Heart palpitations	☐ Serious overeating/under-eating	
☐ Chronic Diarrhea	☐ Hospitalizations	☐ Severe headaches	
☐ Chronic Illness	☐ Major accident	☐ Severe PMS	

Did you experience early language/speech issues or delays? ☐ Yes ☐ No If yes, please explain: _____

_____

Have you ever lost consciousness for a period of time? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you ever stare off into space/appear to be zoned out? ☐ Yes ☐ No If yes, please explain: _____

_____

How much exercise do you get each day: _____

How much caffeine do you get each day: _____

How would you describe your overall diet: _____

How much sleep you get each day, on average: _____

Are your sleep patterns consistent? ☐ Yes ☐ No Would you describe this as restful sleep? ☐ Yes ☐ No

Any sleepwalking, sleep talking, night terror, nightmares? ☐ Yes ☐ No If yes, please explain: _____

_____

History of learning issues? ☐ Yes ☐ No If yes, please explain: _____

History of behavioral/conduct problems? ☐ Yes ☐ No If yes, please explain: _____

_____

History of emotional/mental health-related issues? ☐ Yes ☐ No If yes, please explain: _____

_____

History of inpatient psychiatric care? ☐ Yes ☐ No If yes, please explain: _____

_____

History of suicidal attempts? ☐ Yes ☐ No If yes, please explain: _____

_____

History of addictions (substance, gambling, computer, sex, etc.)? ☐ Yes ☐ No If yes, please explain: _____

_____

History of family violence? ☐ Yes ☐ No If yes, please explain: _____

_____

History of protective orders? ☐ Yes ☐ No If yes, please explain: _____

_____

HISTORY OF STRESSORS

*For each of the following items that apply, write in your approximate age at the time it occurred.

☐ Chronic illness of family member _____
☐ Death of significant person _____
☐ Death of a pet _____
☐ Natural disaster _____
☐ Parents divorced _____
☐ Domestic violence _____
☐ Difficult medical treatments _____
☐ Sexual assault _____
☐ Family member disability/major accident/illness _____
☐ Family member absent (explain) _____, _____
☐ Family member emotional problems (explain) _____, _____
☐ Family member suicide (explain) _____, _____
☐ Separated from parent as a child (how long and when) _____
☐ Other traumas _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

PHYSICAL SYMPTOMS (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods ***WOMEN ONLY***	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

Client Name: _____

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in parts because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

Ms. Acker, Associates, and her staff have the highest level of training and professional expertise. Usually, during the first few sessions, an interview is conducted to review your concerns, your personal and family history and present relationships. Your counselor may choose to ask you to complete various assessment instruments in order to get a comprehensive picture of the issues. The counselor and the client will then develop goals of treatment, strategies involved; explore alternative approaches and/or sources of assistance to meet the client's needs.

The initial consultation, known as an "intake interview," is mandatory for new clients and provides you and your counselor a chance to meet one another and determine if the two of you are a good treatment match. During this meeting, the individual's background, therapeutic concerns and goals, schedule availability and financial resources are discussed and a treatment plan is agreed upon. Details of confidentiality and the therapist's fee will also be discussed.

Following an initial consultation, clients begin meeting with their counselor on a regular basis. Most typically, these sessions are scheduled once weekly for about 45 minutes, depending on the type of counseling used. Depending on the client's needs and treatment goals, he or she may be referred to a psychiatrist for medication prescription and/or management, when appropriate.

Jessica Acker and associates emphasizes customized, individual treatment, carefully suited to the unique needs, wants and goals of the individual client, child, couple or family.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you told me, or even that you are in therapy with me without your prior written permission.

Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family

about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke the permission at any time. You may request anyone you wish to attend a therapy session with you. To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). This law insures the confidentiality of all electronic transmissions of information about you. Whenever I transmit information about you electronically for example, sending bills or faxing information, it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by e-mail at some point in our work together, please be aware that e-mail is not completely confidential. All e-mails are retained in the logs of your or my internet service provider. Any e-mail I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

3. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either A. engaged in sexual contact with a patient, including yourself or B. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board at the Texas Dept of Health. I would inform you before taking this step. *If you are my client and a healthcare provider, however, your confidentiality remains protected under the law from this kind of reporting.*

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couples therapy with me.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy and can be discussed in our joint sessions. Do not tell me anything you wish to be kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Client Name: _____

Unless you prefer otherwise, I will call you by your first name; please call me Jessica. During the time you and I work together, we usually will meet weekly for approximately 45 minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one. Therefore, please do not invite me to social events, bring me gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will benefit the most if our interactions address your concerns exclusively. I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system, exist between us, I will work to understand those differences.

II. Record-Keeping

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else. Should you request a copy of your counseling records, please be aware that a $25.00 record preparation fee will be incurred. An overall counseling summary, in lieu of records, will be provided free of charge upon request. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the *DSM-IV*; I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These

may include their decisions to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating as needed.

Court

I do not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause me to be used in this way. Should you, your attorney, your spouse's attorney, or ex-spouses attorney subpoena me or your client file as a factual case witness or involve me in court-related proceedings, you agree to pay **$75.00 for every hour of my time** involved including case preparation, phone calls with attorneys, travel and witness time, etc. You further agree to pay a retainer fee of **$500.00** at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to our attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

Other Therapy Services

Rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, legal depositions, phone calls over 5 minutes, etc., will be billed at $75.00 per hour in 15-minute increments.

Child Counseling/Play Therapy Logistics

For play therapy, sometimes it may be necessary to end the session early depending upon the following circumstances: the condition or cleanliness of the playroom, the child's ability to leave when the session is over, a situation where play therapy could no longer continue (e.g., child gets sick, child breaks several toys, child chooses to leave and not return, etc.), and the need for a parent consultation. Because the session may need to end early at times, please be sure to remain in the waiting room for most of the session. If you leave the waiting area please let office staff know that you are leaving. When the child greets you in the waiting room following the counseling session, it is best not to ask several questions such as "did you have fun?" While playing is a natural, pleasurable activity for the child, children in play therapy are involved in playing out problems and emotional struggle and, therefore, at times "playing" may not be so enjoyable. Furthermore, when asked what the child did in play therapy, the child will typically respond, "I played". This would be similar to asking an adult in counseling what he or she did in the session –"we talked".

Before your child attends therapy, please take him/her to the bathroom. Play therapy can often be very emotionally freeing, causing the child sometimes to have to use the bathroom during therapy, it is helpful if the child goes to the restroom before the session begins. Also, if your child is coming from school and is hungry, please give him/her a snack before therapy starts. Only in rare circumstances will food be provided for a child in play therapy. In such a situation, this will be discussed with the caregiver and added to the treatment plan. Please know that the playroom has a variety of media that can be

messy (e.g., easel paints, water-color paints, Play-Doh, clay, water, sand, etc.). Please dress your child in clothes that can tolerate mess or possible stains should the child spill paint on him/her. Also, if your child is allergic to any substance that falls into this realm, it is your responsibility to let the play therapist know so that appropriate modifications can be made for your child.

Recording Devices During Sessions

No recording devices are allowed during session. No one is allowed or permitted to record sessions without the expressed consent of both parties prior to the beginning of each and every session.

My Training and Approach to Therapy

I received my MA in Mental Health Counseling from Webster University and a Masters Certificate in Applied Behavior Analysis from the Chicago School of Psychology. I am currently attending Argosy University for my PhD in Educational Leadership. I was awarded my LPC license to practice counseling in May 2005 from Texas My special areas of training working with adults with traumatic brain injuries and PTSD and adults and children diagnosed with autism or developmental delays or behavioral issues.

My approach to therapy is solution focused and cognitive behavioral therapy. This philosophy of psychotherapy looks at the thinking pattern behind our behavior and focuses on finding solutions to our present day issues and concerns. If you would like to learn more about this approach, I have books about it that I can loan to you to read. These techniques are likely to include dialogue, interpretation, cognitive reframing, awareness exercises, self-monitoring experiments, visualization, journal keeping, drawing, and reading books. If I propose a specific technique that may have special risks involved, I will inform you of that, and discuss with you the risks and benefits of what I am suggestion. I may suggest that you consult with a physical health care provider regarding somatic treatments that could help your problems; I refer both to traditional and non-traditional (homeopathic and Oriental medicine) practitioners, and will be involved in a therapy or support group as part of your work with me. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You have the right to refuse anything I suggest. I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of power I have as a therapist.

Therapy also has potential emotional risks. Approaching feeling or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationship you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy has helped.

You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately

from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I am away from the office several times in the year for extended vacations or to attend professional meetings. If I am not taking and responding to phone messages during those times I will have someone cover my practice. I will tell you well in advance of any anticipated lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 pm weekdays or over the weekend), please call the Crisis Line at 779-1800. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for about 45 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling or cancel with less than twenty-four hours notice, you must pay the cancellation or no-show fee at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel. I cannot bill these sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone whose caregiver you are has fallen ill suddenly.

You are responsible for paying for your sessions weekly unless we have made other firm arrangements in advance. My fee for a session is $ 5.00. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up $10.00 every two years. If a fee raise is approaching I will remind you of this well in advance.

If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment at each session. You must arrange for any pre-authorization necessary. I will bill directly to your insurance company via electronic means for you once a month. You must provide me with your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you to cover your balance due, you are responsible for paying me that amount at the time of our next appointment. If the insurance over-pays me, I will credit it to your account or refund it to you if you would prefer that. I am a preferred provider with Triwest, BCBS, Cigna , Aetna, Humana, CCN, EAPs United Behavioral Health.

I am not willing to have clients run a bill with me. I cannot accept barter for therapy; I do accept credit cards and do not take DSHS medical coupons. I am a Medicaid participating provider and accept assignment from them. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and amount due to a collection agency.

Client Name: _____

you want the information. The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.
Other permitted and required uses and disclosures will be made only with your consent, authorization, and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

Signature: _____ Date: _____

Consent for Use and Disclosure of Protected Health Information

I hereby permit and release Jessica Acker LPC, Inc and associates to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. I authorize the Office of Jessica Acker LPC, Inc. to discuss and disclose my personal health information to the individual or insurance carrier provided by me for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. My acknowledgement below further authorizes that the office of Jessica Acker LPC, Inc may consider my signature on this document to authorize the office to use communications through postal mail, email, fax, scanned, or other means to process payments, authorization, or coordination of care on my behalf.

I understand that I have the right to request restrictions of uses and disclosures of my health information; however, this office is not required to agree to a requested restriction. I have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent.

Signature: _____ Date: _____

I have read, understood and hereby agree to abide by all the policies, rules, and regulations as stated in this disclosure statement for the office of Jessica Acker LPC, Inc.

Signature: _____ Date: _____

Jessica Acker LPC, INC

PATIENT RECORD OF DISCLOSURES

You may request to receive confidential communications of your protected health information (PHI) from our office by alternative means or at alternative addresses. For example, you may not want your bills to go to your home where a family member may see them. We will not ask the reason for your request, and we will accommodate all reasonable requests that you make. If you make a special request, you must give alternative addresses or other methods of contacting you.

I wish to be contacted in the following manner (check all that apply and write in phone numbers):

- Home telephone #_____
  __Ok to leave message
  __Leave call back number only
- Work telephone #_____
  __Ok to leave a message
  __Leave call back number only
- Written communication
  __Ok to email to _____
  __Ok to mail to my home
  __Ok to mail to my work/office
  __ Please mail communications to the following address _____
- Cell phone #_____
  __Ok to leave a message
  __Leave call back number only

_____	_____	_____
Patient/Guardian Signature	Print Name	Relationship
_____	_____	_____
Patient/Guardian Signature	Print Name	Relationship

All disclosure will be made pursuant to the guidelines and requirements as detailed in the "Notice of Privacy Practices". Healthcare entities must keep a record of PHI disclosures. Information provided below, if completed properly, will constitute adequate record.

OFFICE USE ONLY						
Date	Disclosed to	(1)	Purpose of disclosure	By whom	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key T= Treatment records P= Payment information
S= dictated summary O=healthcare operations
(3) Enter how disclosure was made: F=Fax P=Phone M=Mail O=Other

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

ATTENDANCE, CANCELLATION AND BILLING POLICY

- Patients who are unable to cancel or reschedule an appointment within 24 hours of an appointment or miss an appointment without providing 24 hour notice, will be charged a $50.00 cancellation or no-show fee.
- Patients who are **more than 10 minutes late**, will have their appointment cancelled and be charged a $50 fee.
- Patients who have cancelled 3 times **with** 24 hour notice will no longer be seen
- Patients who have cancelled 2 times **without** 24 notice will no longer be seen
- Patients who fail to show for their appointments and who do not pay the required fees or cannot be contacted within 24 hours of the missed appointment will have all further appointments cancelled.
- Patients whose insurance company will not allow for a "cancellation/no show" fee to be implemented will be allowed a max of 2 cancellations before they are permanently removed from the schedule.

Please ensure that you are able to make your appointments that are scheduled. As a courtesy we will continue to work with you to remind you of your appointments the day prior to be scheduled but it is still the client's responsibility to make all appointments if no courtesy call is made.

Should you have any questions regarding these charges we encourage you to discuss these with us and/or your insurance carrier. All unpaid balances will be due no later than 30 days following our billing cycle each month.

I fully understand and have had explained to me the office's policy of appointment attendance, cancellations and rescheduling. Since these fees cannot be charged to any insurance company, I agree to remain personally responsible for these charges.

I also understand that billing my insurance is a courtesy service provided by your office and any unpaid balance is my personal responsibility.

_____ _____

Client Signature (parent or guardian if minor patient) Date

_____ _____

Client Signature (parent or guardian if minor patient) Date

INFORMED CONSENT TO TELEMEDICINE/TELEPHARMACY CONSULATION

JESSICA ACKER LPC, 12321 TIERRA HUMEDA, EL PASO TX 79938. 915-691-7130. JAG33313@OUTLOOK.COM

WWW.JESSICAACKER.COM

I understand the following:

1. The purpose is to assess and treat my presented psychological and psychosocial difficulties.
2. Telehealth is done through a two way auto/video link-up whereby Jessica Acker Lpc, EL Paso can see my image on the screen and hear my voice. However, unlike a traditional therapeutic consult, the therapist does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telehealth consultants' practice in a different location does not have the opportunity to meet with face to face, they much rely on information provided by me or any other party for which you release information to through our office. We Jessica Acker INC, cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided to me by yourself or others.
4. I can ask questions and seek clarification of the procedures and telehealth technology.
5. I can ask that the telehealth program,, consultation and/or videoconference be stopped at any time.

6. I know there are potential risks with the use of this technology. These include but are not limited to:
    - Interruption of the audio/video link
    - Disconnection of the audio/video
    - A picture that is not clear enough to meet the needs of consultation
    - Electronic tampering

   If any of these risks occur, the procedure may need to be stopped and postponed.
7. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
8. Reasonable and appropriate efforts have been made to elimate any confidentiality risks associated with telehealth consultations, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultant.
9. I understand that the telehealth consultation will be paid by me or any insurance.
10. I understand I can make a complaint of my provider
11. MAY VISIT: www.dshs.texas.gov/counselor

    Or call: 1-800-942-5540

    WRITE TO:

    TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL

    COUNSELORS

    INVESTIGATIONS

    PO BOX 141369

    AUSTIN TX 78714-1369

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree its contents. I volunteer to its contents. I volunteer to participate in the telemedicine examination. I authorize Jessica Acker LPC to perform therapy and referrals that may be necessary for my current condition.

For questions you may contact Jessica Acker at: 12321 Tierra Humeda, El Paso, TX 79938. Or call 915-691-7130

Signature _____ Date: _____

JESSICA ACKER LPC INC

12321 Tierra Humeda, El Paso, TX 79938

915-691-7130

CREDIT CARD ON FILE

My signature below indicates that I am in agreement with the No Show policy and Late Show policy included in the policies provided to me and if these should arise to allow the office of Jessica Acker LPC INC to bill those charges to the following card information provided below. My signature also indicates that if an explanation of benefits is returned to the office of Jessica Acker LPC INC and indicates a balance doe that their office may also charge those to the following card information provided below.

Notice will be provided to the following phone number by text: _____ of any charges to be billed to the card prior to those charges being made. Any arrangements necessary or adjustments may be made at that time.

You further agree that if at any time this card on file is replaced or you desire to put another card in place that you will contact our office and notify us immediately.

We do our best to verify the insurance you provide. The information we are provided from the insurance company or applicable verification source is what we provide for your convenience and not a guarantee of charges or coverage. If the billed charges result in additional charges you agree to pay that amount to our office through the card listed below.

We encourage you to call your insurance company and verify that mental health services are provided and look into any applicable copays, deductibles or necessary referral or authorization necessary. We cannot be held liable for charges that result from the clients lack of knowledge about their policy.

If there is a court order of child custody in place, regardless of who is designated to pay the charges through a court of law, the individual who initiated the minors treatment through our office will be liable and will need to collect from the other parents separately.

PROVIDE COPY OF CARD OR DEPOSIT

Name on Card: _____

Type of card: CREDIT DEBIT VISA – MASTERCARD - OTHER _____

Number: _____

Expiration date: _____

Code on back of card: _____

Zip code on card: _____

My signature below also indicates that I am the person responsible for the account above and legally able to to be responsible for any charges that are made according to this office policy.

_____Signature _____Print

JESSICA ACKER LPC INC

12321 Tierra Humeda, El Paso, TX 79938

915-691-7130

CREDIT CARD ON FILE

My signature below indicates that I am in agreement with the No Show policy and Late Show policy included in the policies provided to me and if these should arise to allow the office of Jessica Acker LPC INC to bill those charges to the following card information provided below. My signature also indicates that if an explanation of benefits is returned to the office of Jessica Acker LPC INC and indicates a balance doe that their office may also charge those to the following card information provided below.

Notice will be provided to the following phone number by text: _____ of any charges to be billed to the card prior to those charges being made. Any arrangements necessary or adjustments may be made at that time.

You further agree that if at any time this card on file is replaced or you desire to put another card in place that you will contact our office and notify us immediately.

We do our best to verify the insurance you provide. The information we are provided from the insurance company or applicable verification source is what we provide for your convenience and not a guarantee of charges or coverage. If the billed charges result in additional charges you agree to pay that amount to our office through the card listed below.

We encourage you to call your insurance company and verify that mental health services are provided and look into any applicable copays, deductibles or necessary referral or authorization necessary. We cannot be held liable for charges that result from the clients lack of knowledge about their policy.

If there is a court order of child custody in place, regardless of who is designated to pay the charges through a court of law, the individual who initiated the minors treatment through our office will be liable and will need to collect from the other parents separately.

PROVIDE COPY OF CARD OR DEPOSIT

Name on Card: _____

Type of card: CREDIT DEBIT VISA – MASTERCARD - OTHER _____

Number: _____

Expiration date: _____

Code on back of card: _____

Zip code on card: _____

My signature below also indicates that I am the person responsible for the account above and legally able to to be responsible for any charges that are made according to this office policy.

_____Signature _____Print

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

CLIENT NAME _____

PREFERENCE AND OFFICE POLICIES

I understand that the office of Jessica Acker LPC INC frequently uses text to notify clients of appointments. If a reminder is not sent or is not received, this does not waive liability for the scheduled appointments. I recommend using text at (915) 691-7130 for any cancellations. Phone calls with messages or speaking directly with me will also be accepted. No emails will be considered as notice of cancellation.

I request that I be notified by phone or text of upcoming appointments or changes at the following number.

Name: _____ Phone: _____ Relation: _____

If client is a minor both parents have the right to be contacted about any appointment made, cancelled, or changed unless legal documentation is provided states otherwise. I request that if you are bringing in a child to please inform both parents of this decision immediately and provide them and myself with contact information for the other party. Our therapy approach is a family centered practice.

To avoid any conflicts between parties I understand that as a parent of a child, any text that is sent regarding my child may be shared with the other parent. Our office will consider all information provided by either parent as part of the child's file and available to all parties involved with a release of information.

I will not engage in passing messages among parents and ask that conflictual conversations not to be held in my office with the child present. If this occurs one or both parties will be asked to leave. This includes conversations that are counterproductive to therapy, loud or aggressive verbal or nonverbal behavior, threats, cursing, or argumentative.

If an appointment needs to be rescheduled, please do so within 24 hours or a $50 no show fee will be billed and due prior to making another appointment. If you arrive more than 10 minutes late for any appointment it will be cancelled and a no-show fee will be billed. These charges are not billable to insurance and you will be solely responsible for these fees and agree to pay them in a timely manner.

If our office needs to cancel an appointment due to injury, illness or emergency we will contact you as soon as possible. Initiation of a cancellation by our office doesn't waive any fees due to prior balances or fees.

All copays are due by debit, credit, or cash. Electronic invoices may be provided upon request. While we are capable of receiving credit and debit payment, we avoid these so that we do not have to pass along those charges. Medical cards are not always able to be processed, however, we will provide necessary documentation for reimbursement to you for no charge.

If another individual is designated to bring the child to the appointment any applicable fees associated will be billed to the account of file for the client. If you designate any other individual to bring the child, I must be notified prior and receive directly from you a release of information. That individual must almost be at least 18 years old.

_____ Signature _____Printed Name _____Date

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

Client Name: _____ DOB: _____

I authorize the staff at Jessica Acker LPC, Inc., to disclose/use/receive the following protected health information, whether oral, written or electronic (check all that apply):

___Psychiatric Evaluation	___Diagnosis	___Court/Agency Documents
___Psychological Test Results	___Crisis Intervention Reports	___Medical Reports/Records
___Mental Status Information	___Chemical Recovery History	___Medical History
___Treatment plans	___Dates of Hospitalizations	___Discharge Summary
___Progress Notes/Reports		___Appointment times/dates
		___Other: _____

I also authorize the disclosure/use/receipt of my health information regarding (**initials**):

____Psychiatric and Psychological Records
____HIV/AIDS/STD information
____Alcohol and drug abuse treatment information

Jessica Acker LPC, Inc. may disclose to/receive from: _____
(Name of person, organization, or facility)

The purpose for disclosure is:

_____ At my request	_____ To coordinate care with other health care professionals
_____ To discuss with my family the care and treatment I receive	_____ Other _____

**Note: I understand I do not have to sign this authorization to receive treatment or payment processing from Jessica Acker LPC, Inc. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. If I wish to revoke this authorization, I shall do so by delivering a signed and dated letter to Jessica Acker LPC, Inc stating the reason for revocation. The revocation will be effective the date it is received by Jessica Acker LPC, Inc. I also understand that once the designated staff at Jessica Acker LPC, Inc. discloses protected health information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I understand that I may request a copy of this authorization and that a photocopy or facsimile is as valid as the original.

Unless this authorization is revoked earlier in writing, it will expire one year from today's date on: _____

_____	_____	_____
Client/Parent/Guardian Signature	Relation to client	Date

JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

VIDEO RECORDING

IN OFFICE ONLY

This is to provide notice that our office does have video recording in our waiting room and therapy room for safety purposes only. These recording devices do not have the ability to record audio. These recordings are kept securely and only utilized if an event should occur involving the safety of one of my clients or myself. The video segment that will be reviewed or provided in an event or allegation will be restricted only to the specific period of time that this occurred. If you are uncomfortable with this, it will be documented and if we are able to agree we may proceed with sessions. Thank you for your understanding.

INITIAL ONE:

____ I have read and understand this notice and agree to allow the visual recording of the sessions for the sole purpose of safety to JESSICA ACKER LPC INC and clients.

____ I have read and understand this notice but disagree to the visual recording of the sessions. Below I am able to describe the terms I am willing to agree with and agree to discuss these concerns prior to the scheduled meeting to determine if we will be able to proceed.

Signature: _____ Printed: _____