WALKER COUNSELING

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COUNSELING SERVICES POLICIES AND CONSENT
NOTICE OF INFORMATION AND PRIVACY PRACTICES

CONFIDENTIALITY: This is a voluntary agreement unless other wise stated. All information shared is confidential and it will not be made available to anyone unless you have signed a Release of Information. Our practice is dedicated to maintaining the maximum privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

The following are exceptions to confidentiality:

Child abuse, elder abuse, or animal abuse.
Clear and present or imminent danger to self or any other individual.
The court can subpoena all records.
Peer consultation (other therapists) may be utilized.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization to help prevent the threat.
5. If you are a member of a U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate ort under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health related issues in a particular manner or at a certain location. We will accommodate all reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care.
3. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the address listed above
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by and for our practice. To request an amendment your request must be submitted in writing to the address listed above with a reason that supports your request for amendment.
5. Right to a copy of this notice. You may ask us to give you a copy of this notice at any time by contacting us at the address listed above.

6. Right to file a complaint. If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services
7. Right to and authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

RISKS OF COUNSELING: To allow you to make an informed decision about your counseling, you need to understand the risks of counseling. You may experience discomfort such as but not limited to anger, depression, or frustration during your counseling as you address life issues. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. **The greatest risk of counseling is that it may not resolve all your concerns.**

Progress is assessed on a session-to-session basis. Treatment efficacy is modulated by the willingness of the client to cooperate. If a situation fails to improve or deteriorates after an agreed upon length of time, you will be provided with a referral to another professional for consultation or counseling.

MINOR CLIENTS: I affirm that I am the parent/legal guardian of: _____. With an understanding of the above requirements, I do grant permission for my child/children to participate in counseling with William Walker and Walker Counseling LLC.

COUNSELING AGREEMENT: I affirm that prior to becoming a client of William Walker, MA, LCPC Counseling. I have been given sufficient information to understand the nature of counseling, including the nature of the agency, professional identity, possible risks, my responsibility to the counseling process, my financial obligation, the nature of confidentiality including legal and ethical limits under HIPPA, and alternative treatments available.

My signature affirms my informed, voluntary consent to receive counseling from William Walker, LCPC and release William Walker LCPC and Walker Counseling LLC from any liability.

I have read the above and understand what is stated. I understand that I may terminate this relationship at any time by notifying the undersigned counselor.

FEES: **Payments are due at the time of service**, unless otherwise pre-arranged.
An income sensitive sliding scale is available upon your request.
Common charges are as follows:

Individual 50-60 min.	**$125.00**
Couple/Family 50-60 min.	**$135.00**
Group 1hour	**$45.00**
Cancellations 24 hour notice	**No Charge**
Emergency cancellation	**No Charge**
Cancellation same day	**½ fee**
No show/no call	**Full fee**
Returned check fee	**$25.00**
Court appearance	**$175.00/hr.**

We do not carry balances: Accounts that become **60 days past due** with no arrangement for payment will be put in a collectable status and the appropriate steps will be taken to secure payment from you. If it is necessary to refer your account to collections you will be billed the additional costs and fees resulting from this referral.

INSURANCE: I / we authorized assignment of insurance payments to: Walker Counseling LLC, William Walker LCPC.

You are ultimately responsible for all fees incurred including fees required for collection if your account becomes more than 60 days past due.

Client_____ Date_____

Client_____ Date _____