CONNIE HEAPS, MA, LPC
5617A Adams Avenue
Austin, Texas 78756

Contact: 512-458-8377 (Work) 512-785-7788 (Cell)
Email: connieheaps@platinumhosting.com

PERSONAL DATA

Date: _____
Client Name: _____
Home Address: _____
City/State/Zip: _____

Contact Telephone Numbers: Can I contact you at this location & leave a message?
Home: _____ **Yes/No**
Work: _____ **Yes/No**
Cell: _____ **Yes/No**
Email: _____

Insurance Information:
Name of Insurance Company _____ **(Insurance Reporting)**
Subscriber Name: _____
Insurance ID#:_____
Group #:_____
Coverage Date:_____
DOB: _____

Social Security Number: _____
Age: _____
Occupation: _____
Referred by: _____
Reason for visit: _____
_____
_____
_____

HIPAA Compliance

The attached HIPAA notice describes how mental health information about you may be used and disclosed and how you can get access to the information. Please review it carefully. If you have any questions about this notice please let me know.

This Privacy Notice tells you about your rights about your mental health care records. You may review this request at any reasonable time or you may request a copy. A new government rule requires that I give you this Privacy Notice to sign.

My policy has always been to keep your records safe. Your records are usually kept in a folder of papers with your name on it. Your records can also be stored in a computer or locked file cabinet. Your records tell what analysis and treatments you have had, and what decisions the counselor has made.

By signing below, you attest that you have read and have been made aware of your rights of confidentiality as a mental health consumer. Full HIPAA compliance Rules and Regulations are posted in my therapy office at all times and may be read and copies furnished upon your request.

Client's Printed Name	**Relationship to Patient**
Client/Guardian Signed Name	**Date Signed**

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: I am a Licensed Professional Counselor. My formal education has prepared me to counsel individuals, couples, parents and families.

Nature of Counseling: My theory of counseling is that people have specific behaviors they would like to change, which may be caused by irrational, self-defeating beliefs learned early in the developmental cycle. Due to these beliefs and/or experiences with various traumatic events, individuals may experience life as unmanageable. My goal will be to assist clients with changes in irrational beliefs, working through traumatic life events as well as working with the stress component associated with physical pain and illnesses. I am a psychotherapist and have certified credentials in Internal Family Systems (IFS), Eye Move Movement Desensitization and Reprocessing (EMDR), and Emotional Transformation Therapy (ETT). I have been licensed as an ETT Teacher & Consultant in this field. I have assisted in trainings as a Program Assistant (PA) in Internal Family Systems trainings. I also have a background in Developmental Needs Strategies (DNMS) & Neurofeedback even though I am not actively practicing in those two fields today. I have worked with trauma, anxiety, depression, and various other mental health conditions as well as life changing events. Some of my clients are active in a 12 step programs.

INFORMED CONSENT

Counseling Relationship: Sessions are scheduled in 50 to 55 minute sessions with the number of sessions per week dependent upon the client's symptoms and needs. Our sessions may be very intimate psychologically but ours is a professional relationship rather than a social one. You will be best served if our sessions concentrate exclusively on your concerns.

Our sessions will be limited to the counseling sessions you arrange with me and I schedule appointments based on availability and your need. If you experience a mental health emergency, obtain crisis services by dialing 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client's Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session or complete termination paperwork if a termination session is not feasible. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors, P. O. Box 141369, Austin, Texas 78714-1369 or by calling 1-800-942-5540 to obtain more information.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, I encourage you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with me, you agree not to maintain or establish a professional relationship with another mental health professional unless you discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors.

I also reserve the right to postpone and/or terminate counseling of clients who come to session under the influence of alcohol or drugs.

TELE-HEALTH INFORMED CONSENT

The tele-mental health services in this case will involve the use of video conferencing to provide counseling services. This document solely outlines consent for tele-mental health services. Please refer to the general informed consent for full-service outline. Please note that the terms outlined in the general informed consent are applicable in addition to this agreement and by signing this agreement, you are acknowledging that you accept the terms of both consent forms.

You are encouraged to clarify any concerns or questions with your therapist, and you have the right to terminate tele-mental health services at any time.

Program Used

Connie Heaps, Licensed Professional Counselor uses a HIPAA compliant Zoom telemedicine program to provide video conferencing counseling services. The Zoom Telehealth program is free to clients via a link or via a mobile app. The HIPAA-compliant Zoom program abides by the Health Insurance Portability and Accountability Act of 1996 and the Privacy Rule and is mandated to their standards and regulation. The HIPAA complaint Zoom program abides by the Health **Benefits and Risks of Tele-mental health and Confidentiality.**

Tele-mental health services allow clients to have more access to services and offers more flexibility. Services can also benefit clients who are not available to attend a session on-site, those who are physically disabled and those clients who experience extreme social anxiety or agoraphobia which hinders one's ability to receive face-face counseling.

Risks from tele-mental health counseling, include, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPPA-compliant service which is encrypted for video tele-mental health communications.

The therapist will also only conduct sessions in private but cannot control the steps that will be taken on the client's end that impact the security of privacy and confidentiality. Sessions will not be recorded by the therapist without prior written consent.

If the therapist believes that you would be better served by another form of psychotherapeutic services (i.e. face to face), he will work with you to switch the form or you will be referred to therapists in your area who provide such services.

I have read and understand the information discussed above. I have discussed any questions or concerns with my therapist, and I have been provided information to my satisfaction.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by HIPAA-compliant Zoom is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and if a password is required, it will be provided with the Zoom link. By signing this document, I acknowledge:

1. HIPAA-compliant Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Zoom nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by HIPAA-compliant Zoom facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by this Zoom Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by the HIPAA-compliant Zoom Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

☐ I agree and sign this document

Cancellation Policy: In the event that you will not be able to keep an appointment, please notify me during business hours (Monday through Friday) at least 24 hours in advance, whenever possible. If this 24-hour notice is not respected, you will be billed for your session. By notifying me 24 hours in advance, it allows me to fill that time slot with another client who may be in need of counseling at that time.

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment with me. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: Please read "Fee For Services" form before signing below.

Records and Confidentiality: All of our communication becomes part of your clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of five years after the client's 18th birthday. All of our communication is confidential, except in the following cases: a) I am using your case records for purposes of supervision, professional development and research. In such cases, to preserve confidentiality, I will identify you by first name only or by assigning a number to your name; b) I determine that you are a danger to yourself or someone else; c) You disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) You disclose sexual contact with another mental health professional; e) I am ordered by court to disclose information; f) You direct me to release your records; or g) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first or I will acknowledge you but not disclose how we know each other.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

By your signature below, you are indicating that you read and understand this statement, or that any questions you had about this statement were answered to your satisfaction, and upon request were furnished a copy of this statement within a reasonable time frame.

By my signature below, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____ _____

Client/Guardian's Signature Date

FEE FOR SERVICES

My fee is $140 per 50-55 minute session. Payment is due at each session. If I am a provider with your insurance company, I will file your insurance. If I am not on your insurance plan, upon request, I will provide you with a "super bill" if you wish to file a claim for "out of network" insurance reimbursement. Any dispute over insurance reimbursement is between you and your insurance company.