Emerge Art Therapy and Counseling, PLLC
JaeJeung So, LPC-S, ATR-BC, CTT
413 W Bethel Rd # 100, Coppell, TX 75019 (972) 393-1596 ext. 53

Informed Consent

Welcome to my practice. Thank you for trusting me with your care. Please carefully read the information in this packet and please do not hesitate to ask any questions you may have. You will be asked to sign a "Consent to Treatment" form once you have read and understood the information in this packet and prior to beginning treatment.

Therapy Services: Therapy is a collaborative partnership between the client and therapist. Therapeutic work will be directed toward mutually determined goals. To achieve the best results possible, your active participation and commitment are required, and it will be important for you to explore your feelings and thoughts, as well as, try new approaches. Therapeutic work is a personal exploration and may lead to changes in your perspectives, behaviors and relationships. Together, we will work toward the best possible outcomes for you. While benefits are expected from this work, no specific results can be guaranteed. Please discuss any concerns or confusion you might have about treatment with me. If I should determine, following the intake appointment or any time during the course of treatment, that a referral is appropriate in order to address your specific needs, one will be provided, and it will be your responsibility to contact and engage those resources.

Art Media and Art Work: As Board Certified Art Therapist, I may use art making in session when clinically appropriate. Art media necessary for treatment will be provided by me but you may choose to bring your media of choice if I determine that it is safe and appropriate. Artwork created during session may be taken home or left with me for temporary storage as space permits. If you choose to leave your artwork with me and space permits, I can securely store it for you until termination of treatment or 6 months after its completion date, whichever date occurs first. Artwork that is not claimed within the above mentioned time may be discarded after identifiable information is removed. Photograph of artwork may be kept as part of your treatment record.

Court Policy: If you are seeking counseling for your minor child and are divorced, separated, or currently involved in any legal proceedings, you must submit a hard copy of your current divorce decree and any additional orders currently in effect that supplement the decree. In so doing, you are documenting that you have the legal right to seek counseling for your child. Additionally, if you become involved in a divorce or custody dispute, please understand that I will not provide evaluation or expert testimony in court. In the event disclosure of your records or my testimony is requested or required, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged at the time of the request or service of subpoena with a minimum of 4 hours billed (current rate is $250 per hour). Additionally, you are responsible for time spent in travel for local hearings, time spent in review, preparation and consultation, travel expenses and any on-call or waiting time. Payment is required 72 hours prior to when the services are to be rendered and any additional fees will be billed, and payment must be made, within 72 hours after service is delivered. You are also responsible for any legal fees I may incur related to your case (litigation, representation, lack of payment, etc.). A deposit may be required for anticipated court appearances and preparation.

Scheduling and Fees: Therapy sessions, intakes and consultations are by appointment only and will typically last 50 minutes. Payment is due at the time services are rendered and billed at a rate of $130 per session. Sessions are typically scheduled for once a week but may vary in frequency or duration depending on the specific treatment plan or the type of session. Payment will be collected before your session begins. Cash, checks and

credit cards are accepted. Returned checks will be charged a $25 fee. Your session time is reserved just for you. Late arrivals will not extend the scheduled session or alter the fee. Any cancellations must be made with at least 24 hours advance notification by calling 972-393-1596 #53. **Failure to cancel an appointment with a 24 hours' notice will result in a late cancellation fee of $50. Not attending a scheduled appointment or cancelling an appointment with less than an hours' notice will result in a no-show fee of $130.** For any missed or cancelled appointments, it is your responsibility to reschedule. Multiple missed appointments or late cancellations may result in termination of services. Clients arriving for services who appear to be under the influence of substances which may cause impairment (alcohol, prescription or illegal drugs, etc.) will not be seen and will need to secure safe transportation from the office. In support of the health and well-being of clients and staff, no smoking, e-cigarettes or tobacco use is allowable. Weapons of any kind are prohibited. For the health and safety of all, only service animals trained to provide assistance to an individual with a disability will be permitted.

Crisis Care, Communication Between Sessions, & Professional Relationship: Please note that I do not provide 24-hour crisis or emergency therapy services. If you are experiencing a mental health emergency, please call 911, go to your nearest emergency room, or call one of the following hotlines: Suicide and Crisis Center of North Texas (214-828-1000) or the National Suicide Prevention Lifeline (800-273-8255). You may contact me via phone between sessions for scheduling and minor, non-emergency issues. Please understand that I may be in session or out of the office and may not be able to return your call immediately. I do my best to try to ensure that calls are returned by the end of the next business day. Phone sessions may be set up occasionally under certain conditions. Phone sessions will result in a full fee for a counseling session or a fee of $32.50 per quarter hour. Please note that email is not a secure form of confidential communication. Email must be limited to scheduling and should not contain private, sensitive and/or therapeutic issues or concerns. Additionally, I will not accept friend or contact requests from any clients, past or present, on any social media sites. Any requests to engage using social media will be denied to ensure privacy. To honor the integrity of the relationship and to protect both therapist and client, I strictly adhere to the code of ethics set forth by my licensing board. Although therapy sessions may be very personal, the relationship is a professional rather than social one.

Confidentiality and Records: Your privacy and confidentiality are highly valued. Our communications over the course of therapy become part of your protected health information, recorded in your client file, which will remain confidential and securely stored. You will be notified when disclosure of your records is required by law. Records will be destroyed five years after the termination of services delivered. Please refer to the notice of privacy practices in this packet. Please be aware of the following exceptions to confidentiality:

- You provide consent to release your records or share information regarding your treatment.
- You are at risk of imminent serious harm to yourself or others. (In which case your therapist will contact proper authorities. Medical and/or law enforcement personnel may be notified with or without your consent)
- You disclose known or suspected abuse, neglect or exploitation of a child (17 and under), a person with a disability or an elderly person (65 and older).
- You disclose sexual misconduct of a physician or therapist.
- A court order is received to disclose information.
- You file a complaint with a licensing board or in cases of a malpractice suit (records will be released to the board and to legal counsel).

In the case of my death or incapacity, I have made provisions for another mental health provider to take possession of all client records. In such a situation, you can request copies from the designated provider or request that copies of records be delivered to a therapist of your choosing.

Client Rights and Termination of Services I take the privilege of serving clients very seriously and I strive to provide a safe environment for clients and staff alike. Some clients may require only a few sessions to achieve their goals, while others may require months or sometimes even years of treatment. We will collaborate on a plan for treatment specific to your needs and goals. You have the right to terminate therapy at any time. In such cases a termination session is highly encouraged. In circumstances where I have reason to believe service to a client is no longer a need, not in the best interest of the client and/or may potentially jeopardize the safety and well-being of other clients and staff, I may refuse to serve or terminate services. Any behavior or language that is seen as threatening, violent or abusive will result in the refusal or termination of services and the potential involvement of appropriate authorities. Should you ever have any concerns about your treatment, please notify me immediately. I will make every effort to hear any concerns you have and to seek solutions collaboratively with you. If you believe that I have not behaved in an ethical or professional manner, you may report your concerns to the Texas State Board of Examiners of Marriage and Family Therapists, Texas Department of State Health Services, Mail Code 1982, PO Box 149347, Austin, TX 78714.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations -I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

a. "PHI" refers to information in your health record that could identify you.
b. "Treatment, Payment and Health Care Operations" – Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. -Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
c. "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
d. "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization -I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for

information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization I may use or disclose PHI without your consent or authorization in the following circumstances:

a. **Child Abuse**: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
b. **Adult and Domestic Abuse**: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
c. **Health Oversight**: If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
d. **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
e. **Serious Threat to Health or Safety**: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
f. **Worker's Compensation**: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor's Duties

a. **Patient's Rights**:
   i. **Right to Request Restrictions–** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
   ii. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations –** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
   iii. **Right to Inspect and Copy–** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
   iv. **Right to Amend**– You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

v. **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

vi. **Right to a Paper Copy**– You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

b. **Counselors Duties**:

i. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

ii. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

iii. If I revise my policies and procedures, I will notify you in person or by mail and post changes on the web site

V. Complaints: If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at the above phone or address. If you believe I have violated your privacy rights, you may contact your Privacy Officer, JaeJeung So, LPC-S, ATR-BC, CTT at 413 W Bethel Rd # 100, Coppell, TX 75019; (972) 393-1596 ext. 53. You also have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. I will not retaliate against you for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on June 15th 2018. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by in person or by mail and posting on the web site.

Receipt and Acknowledgment of Notice of Privacy Practices

_____ _____

Client Name Date of Birth

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices for the practice of JaeJeung So, LPC-S, ATR-BC, CTT at Emerge Art Therapy and Counseling, PLLC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact JaeJeung So, LPC-S, ATR-BC, CTT at (972) 393-1596 ext. 53.

_____ _____

Client or Parent/Guardian Signature Date

Emerge Art Therapy and Counseling, PLLC
JaeJeung So, LPC-S, ATR-BC, CTT
413 W Bethel Rd # 100, Coppell, TX 75019 (972) 393-1596 ext. 53

CREDIT CARD AUTHORIZATION FORM

Scheduling and Fees

_____**Therapy sessions are billed at a rate of $130 per session.** Sessions extending beyond the typical 50 minutes may incur additional fees.

_____**Phone sessions are billed at a rate of $130 per full session or $32.50 per quarter hour.**

_____**Failure to cancel a session without 24 hours' notice will result in a missed session fee of $50 per missed appointment and will be billed to the card on file.** This applies to all late cancellations, regardless of reason. Please note that this fee is not covered by insurance and is subject to change.

_____ **Not attending a scheduled appointment or cancelling an appointment with less than an hours' notice will result in a charge for the full session fee of $130 and will be billed to the card on file.** This applies to all no shows, regardless of reason. Please note that this fee is not covered by insurance and is subject to change.

I, _____hereby authorize JaeJeung So at Emerge Art Therapy and Counseling, PLLC, to charge my credit card on my behalf for all services provided from this day on in accordance with the fees listed above.

In the event of a credit card dispute, this serves as consent for JaeJeung So to release this consent/authorization form to the credit card company or bank involved.

Credit Card Number:_____

Credit Card Expiration Date: _____

Security Code: _____

Name as it appears on card: _____

Card owner billing address:

Street: _____

City State, Zip Code: _____

Card owner phone number: _____

_____ _____

Signature Date

Emerge Art Therapy and Counseling, PLLC
JaeJeung So, LPC-S, ATR-BC, CTT
413 W Bethel Rd # 100, Coppell, TX 75019 (972) 393-1596 ext. 53

Consent to Treatment

I, _____, have reviewed the following and my initials by each indicate that I understand, agree to, and will comply with each requirement:

_____ I have read and received a copy of the Informed Consent, the Notice of Privacy Practices, and have had the opportunity to discuss the information found therein with my therapist/my child's therapist. I know that I can ask about any of this information at any time with my therapist/my child's therapist throughout the course of treatment. I understand that I have the right to withdraw my consent to treatment at any time, for any reason. However, I will make every effort to discuss my concerns before ending therapy.

_____ I understand the limits to confidentiality as outlined in the Informed Consent and the Notice of Privacy Practices.

_____ I understand no specific promises have been made to me about the results of treatment, the effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective. I understand the benefits and risks of therapy.

_____ I understand the structure around scheduling, appointments, and crisis needs.

_____ I agree to pay for services at a rate of $130 per session. I understand that missed appointments and cancellations made within 24 hours of my appointment will be charged at a rate of $50. I understand that cancellations within an hour to my appointment time, or appointments missed without any cancellation will be charged the full $130 fee. I agree that my credit card on file will be charged for those sessions.

_____ I agree to act according to the points covered in the Informed Consent. I hereby agree to enter into therapy/have my child enter into therapy with JaeJeung So, LPC-S, ATR-BC, CTT and to cooperate to the best of my ability, as shown by my signature below.

_____ _____

Client or Parent/Guardian Signature Date