Sari Niemi, M.S., LPC, LSSP

413 West Bethel Rd., Suite 100
Coppell, TX 75019
Phone: (972) 393-1596 Ext. 59

Welcome to my office!

Thank you for contacting me and making the first appointment. I am looking forward to working with you. Please review the paperwork carefully before our first appointment and sign where it is indicated. If you have any questions, I will be happy to help you during our first appointment. When you arrive at my office, please press the button on the light panel next to my name to the left of the reception window. I will be out shortly to greet you. I am looking forward to helping!

Sincerely,
Sari Niemi, M.S., LPC, LSSP

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to me. I will maintain the privacy of your health information and will not disclose the information unless you tell me to do so, or unless the law authorizes or requires me to do so. It is important that you know about the rules of confidentiality now.

A federal law commonly known as HIPAA requires that I take additional steps to keep your informed about how I may use information that is gathered in order to provide health care services to you. As a part of this process, I am required to provide you with the attached Notice of Privacy/ Confidentiality Practices and to request that you sign the attached written acknowledgement to indicate that you received a copy of the Notice.

Please review the following information carefully. If you have any questions about this Notice, please contact Sari Niemi at 972-393-1596 ext. 59.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
A. Permissible Uses and Disclosures without Your Written Notice:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. For example, I may use PHI to diagnose and provide counseling services to you. In addition, I can disclose PHI to other health care providers involved in your treatment or to consult about your care.

For Payment. I may use or disclose PHI so that we can receive payment for the treatment services provided to you, billing for health care, or payment collection. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our health care operations, Employee Assistance Programs, including quality improvement activities, training programs, accreditation, certification, licensing, or credentialing activities.

Required by Law. Under the law, I am permitted to disclosure of your PHI when I am required or it is permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of an abuse, neglect, or domestic violence or the possible victim of other crimes. Additionally, I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health care activities; health oversight activities including disclosures to state or federal agencies authorized to access to PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

B. Uses and Disclosures Requiring Your Written Authorization:

Psychotherapy Notes: Notes recorded by you clinician documenting the contents of a counseling sessions with you will be used only by your clinician and may not be used or disclosed without your written authorization, except when legally requested.

Marketing Communication: I will not use your health information for marketing communications without your written authorization.

Other Uses and Disclosures: Other disclosures other than those described in section A. above will only be made with you written authorization. For example, you need to

sign an authorization form before I can send you PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

YOUR RIGHTS REGARDING YOUR PHI

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI. All requests to access must be made in writing. Under limited circumstances, I may deny access to your records. We may charge a reasonable, cost-based fee for copies. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical records will not be accessible to you.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I have made of your PHI. The right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. You must request such restrictions in writing addressed to the Privacy Officer as indicated below. I am not required to agree to such restrictions you may request.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself

- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you want more information about your privacy rights or believe I have violated your privacy rights, you may contact the Privacy Officer, Sari Niemi M.S., LPC, LSSP at 413 W. Bethel Rd., Coppell TX 75019 972- 393- 1596 ext. 1596. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I **will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2003.

I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will provide you a revised notice.

Sari Niemi, M.S., LPC, LSSP
413 West Bethel Road, Suite 100
Coppell, TX 75019 Phone: (972) 393-1596 Ext. 59

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB:_____SSN:_____

I hereby acknowledge that I have read, understand, and received a copy of Notice of Privacy Practices for Sari Niemi M.S., LPC, LSSP. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, Sari Niemi, at 469-718-9606.

_____
Signature of Patient/Client

_____
Signature or Parent, Guardian or Personal Representative*

_____
Date

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):*

Name: _____
Relationship to Client: _____

❑ ***An acknowledgement of receipt of Notice of Privacy Policies were attempted but the Patient/Client Refuses to Acknowledge Receipt:***

_____
Signature of Staff Member **Date**

Practice Policies

Sari Niemi, M.S., LPC, LSSP

Welcome to My Practice!

I am a licensed professional practitioner and provide counseling services at Coppell Counseling Center. I received my Bachelor of Science in 2007, Master's in Counseling Psychology in 2009, and Master's in School Psychology in 2012 degrees from the University of North Texas. I am licensed as a Licensed Professional Counselor (LPC) and Licensed Specialist in School Psychology (LSSP). My past experience has enabled me to work with culturally diverse populations with different ethnic backgrounds in individual, group, and family counseling settings as well as completing psychological assessments. I enjoy working with children, teenagers, and adults and some of my interventions have included helping individuals to gain a better self-esteem, alleviating symptoms of depression and/or anxiety, leading to cope better with loss and grief, and helping parents to work better as a team to deal with their children's behavior problems using positive behavior supports. I moved to Coppell from Finland in 1999 and have lived in this community since with my two teenage children. Yes- I speak Finnish too!

CLIENT/THERAPIST RELATIONSHIP: Even if the counseling sessions are used to discuss sensitive, personal information, our relationship is a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. I will respect our confidential relationship if I meet you in public by acknowledging you only if you approach me first. Gifts are not appropriate, nor is any sort of trade of service for service.

What to Expect: I follow all ethical standards prescribed by state and federal law and the ethical rules by my licensing board, and keeping your information confidential is important to me. We are required by practice guidelines and standards of care to keep records of your counseling experience. These records are confidential with the exceptions in the Notice of Privacy Practices provided to you.

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

Your first visit will be an assessment session in which we will determine your concerns, go over important paperwork, and set preliminary goals for our upcoming session. I will do everything possible to provide positive counseling experience to you. If I cannot provide the professional care you need or you would like to consult another counselor, I will be happy to refer you to someone who may help you with your concerns.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45 to 50 minutes long unless otherwise agreed upon. If you must cancel or reschedule your appointment, please notify me at least 24 hours in advance, whenever possible. In case the appointment is cancelled in less than 24 hours or no prior notice is given, you **may be charged a full fee for missed appointments.** You can reach me at 469-718-9605 or by email at saricounselor@gmail.com. The initial

session fee is $120 and then each session $100, unless we have agreed upon insurance coverage or made other arrangements. You are responsible for any authorization, fees, or co-pays at each visit. I accept all major credit cards with an additional fee of 2.75%, check, and cash for payment. I will provide a receipt for third party reimbursement, **if requested. A fee of $25 is added to returned checks.** A reasonable fee will be charged for copies of any records requested by the client. The payment is due at the time of service. Please understand that if payment for the services is not made, the therapist may stop my treatment and seek to collect the fees.

I am trained completing testing for intellectual ability school achievement, learning disability, and any presence ADHD or any other emotional difficulty. If you are interested in any of these services, please let me know, and we can talk about the best option for you.

EMERGENCIES: You may encounter a personal emergency, which will require prompt attention. In this event, please contact me regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. In rare occasions, we can have a session on the phone but the regular session fee applies. If you are experiencing a life-threatening emergency, please call 911 or have someone take you to the nearest emergency room for help. When I am out of town, you will be advised and given the name of an on-call therapist. Upon my death or incapacitation, your records will be stored with Ms. Kimberly Hatley, LPC, LMFT, here at the same office address. I generally keep your records 5 years past the date of our last appointment.

Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you
- Have a safe treatment setting, free from sexual, physical, and emotional abuse
- Report immoral and illegal behavior by a therapist
- Ask for and get information about the therapist's qualifications, including his/her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice
- Have written information, before entering therapy, about fees, methods of payment, insurance coverage, number of sessions, the therapist will think you need, substitute therapist, and cancellation policy
- Refuse audio or video recording of sessions (but you may ask for it if you wish)
- Refuse to answer any questions or give information you choose not to answer r give
- Know if your therapist with discuss your case with others (e.g. supervisors, consultants, or students)
- Ask that the therapist inform you of your progress

If you have any complaints about my services, please discuss any concerns with me at once. I encourage my clients to share any feelings or thoughts they have, which facilitates the counseling process and ensures that I am providing you what you need. If you would like to make a formal complaint, please contact:

Texas State Board of Examiners of Professional Counselors
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
Email:lpc@dsjs.state.tx.us Telephone: 512-834-6658 Fax: 512-834-6789

Texas State Board of Examiners of Psychologists
Enforcement Division
333 Guadalupe, Tower 2, Room 450
Austin, Texas 78701
Telephone: 512-305-7709 toll free: 800-821-3205 Fax: 512-305-7701

CONSENT TO TREATMENT:

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

_____ _____
Signature – Client/Parent Date

_____ _____
Signature – Spouse/Partner/Parent Date

_____ _____
Therapist Date

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

_____ _____
Client/Parent Date

I authorize the payment of medical benefits to the provider of services.

_____ _____
Client/Parent Date

CLIENT INTAKE FORM

(Please Print)

Today's Date:_____

Name:_____ DOB:_____ Age:_____

Nicknames or Aliases:_____ SSN#_____

Address:_____ Apt:_____

City, State, Zip Code:_____

Home Phone:_____ Cell phone:_____

Email address:_____

I can contact you by phone: _____ yes _____ no initials please_____

I can contact you by email: _____ yes _____ no initials please _____

Referral Source

You received my information from:

Name:_____

Address: _____

Phone: _____

I can contact this person to thank her/him for the referral: _____ yes _____ no

Religious/ Ethnic Identification

Religious denomination:

____ Protestant _____ Catholic _____ Jewish _____ Islamic _____ Buddhist ____ Hindu

Other (specify): _____

How important are spiritual concerns in your life?

_____

_____

Ethnicity/National Origin:_____ Race: _____

In case of an emergency, who can I contact?

Name:_____ Relationship:_____
Address:_____
Phone:_____

Client Basic Information

Client's name:_____

Name of Primary Care Physician:_____

Physician's address:_____

Physician's phone:_____
May I talk to your primary physician to better coordinate treatment?

___ Yes ___ No Initials _____ Date of last medical evaluation:_____

History:
Please list all major illnesses, accidents, surgeries, hospitalizations, medical conditions, etc. from you childhood until present:

_____
_____
_____
_____
_____

List all medication you are currently taking and the purpose for taking it:

1) _____ Dosage/freq._____ Start date_____ Purpose_____
2) _____ Dosage/freq._____ Start date_____ Purpose_____
3) _____ Dosage/freq._____ Start date_____ Purpose_____
4) _____ Dosage/freq._____ Start date_____ Purpose_____

Are there any medical or physical problems you are worried about?

_____
_____
_____
_____
_____

Family
Please list all your family members, your relationship with them, and their age:

_____
_____
_____
_____
_____

Please indicate which of these things may be part of your family history:

	Immediate Family			**Mother's Family**			**Father's Family**		
	Mother	Father	Siblings	(grand) Mother	(grand) Father	Other	(grand) Mother	(grand) Father	Other
Childhood aggression or oppositional behavior									
Problems with attention or hyperactivity (or ADHD)									
Learning disabilities									
Did not graduate from High School									
Mental Retardation									
Genetic syndromes									
Treatment for depression or bipolar disorder									
Suicide attempt/completion									
Psychiatric hospitalization									
Treatment for anxiety disorder									
Tics or Tourettes									
Epilepsy									
Abuse (physical, emotional, or sexual)									
Incarceration									
Schizophrenia/ psychosis									

List any condition not listed above:

Describe your relationship with your family members:

What would you like to accomplish during our work together?

What have you attempted to do to help yourself with the above mentioned issue?

Have you met with other mental health providers and how was your experience with them?

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ___frightened ____guilty
____angry ____ashamed ____aggressive ___resentful
___worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:

_____
_____
_____

What activities or hobbies do you participate in?

_____
_____
_____

Do you participate in regular exercise? (Circle One) YES NO
Describe:_____

Describe your current working/ school environment:

_____
_____
_____

Do you have any difficulties in your current working/school environment?

_____
_____
_____

Have you had any change in sleeping habits? (Circle One) YES NO
Describe:

_____
_____
_____

Have you had any change in eating habits? (Circle One) YES NO
Describe:

_____
_____
_____

Thank you☺