Alternative Life Solutions Counseling, PLLC
2458 East Eleventh Street
Odessa, TX 79762
432-582-2444

Date: ________________________

PARENT'S PERSONAL INFORMATION

Last Name: _____________________________________ First: _________________________ Middle: ____________

Address: ____

City: ____ State: ________________________ Zip: _______________

May we mail to you at this address? □ Yes □ No

If no, alternate address is required: ____

Date of birth: ___________________________________ Age: ________ Gender: M F O

Please provide and initial to indicate we may leave messages at:

___ Home Phone: ______________________________ Can detailed messages be left at this number ____

___ Work Phone: ______________________________ Can detailed messages be left at this number ____

___ Cell Phone: ______________________________ Can detailed messages be left at this number ____

___ Text reminders are sent by our scheduling services. Initial if you wish to receive text reminders.

___ eMail: ______________________________________

____ Consent to being contacted by text messages by therapist or staff for appointment changes and other forms of communications

Emergency Contact:

Authorization to Disclose Protected Health Information form must be signed before anything other than your name and the fact of the emergency will be disclosed.

Name: ____ Phone Number: ____________________________________

Client Relationship to Emergency Contact: ____

INSURANCE INFORMATION

Insurance Company: ____________________________ Insurance Phone Number: __________________________

Insurance Provider Address: __________________________ City: ______________________ State: ________ Zip: __________

ID Number: ____________________________________ Group Number: ___________________________________

Policy Holder Information:

Name: ______________________________ Date of Birth: ______________________________

Social Security Number: __________________ Employer: ______________________________

Client Relation to Policy Holder: __________________________

Who referred you to Alternative Life Solutions? ______________________________________

Or Web search through Psychology Today Therapist Locator

Medical and Counseling:

Are you currently under medical care? □ Yes □ No

If yes, please indicate reason: ____

Physician's Name: ______________________ Phone Number: __________________

List and prescription medication(s): ____

Other Significant Medical History: ____

COUNSELING HISTORY

Have you ever received psychotherapy/counseling? □ Yes □ No

Name/Location/Dates: _______________________ ________________________________

Reason for Previous Counseling: ____

Do you currently have a Psychiatrist: _______
Name of psychiatrist _______________________ Phone Number: ________________________

EMPLOYMENT
□ Full-time □ Part-time □ Self-employed □ Unemployed

Employer: ____________________________ Job Title: ______________________________

How long at current job: __________________

EDUCATION
Highest level of education:
□ High school □ Some college □ Professional training □ College degree □ Graduate degree

Other: ____

FAMILY INFORMATION:

Your Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widow(er) □ Living with Partner/Significant Other

Your children: Name(s) Age(s) ____

Do these children live with you, if so which ones? ____

If divorced or other do you or your spouse have custody or shared arrangement? ________________

____

If you have children, describe your relationship with each child ____________________________

____

Parents of child's Parents:

Mother: Living, age: ______ Year Deceased _____ *Father:* Living, age: _________ Year Deceased ________

If parents are living describe your relationship with each of them: ___________________________

____

PARENT HOUSEHOLD INFORMATION

FIRST NAME (OPTIONAL)	SEX	AGE	RELATION TO YOU	OCCUPATION

OTHER SIGNIFICANT PEOPLE (PLEASE SPECIFY RELATIONSHIP--spouse, partner, friend, sibling, parent, guardian, etc.)

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____

____

CHECK ANY OF THE FOLLOWING ITEMS THAT CURRENTLY CONCERN YOU OR APPLY TO YOU THE PARENT. Check twice those items that are of most concern to you:

____ RELATIONSHIP WITH PARTNER/SPOUSE

____ RELATIONSHIP WITH FAMILY MEMBERS

____ DEATH OR LOSS OF SIGNIFICANT PERSON

____ RESTLESSNESS, RACING THOUGHTS

____ DATING / ROMANTIC RELATIONSHIPS

____ SPIRITUAL CONCERNS

____ SEXUAL CONCERNS

____ RELATIONSHIP WITH FRIENDS / ROOMMATE

____ ANGER, IRRITABILITY

____ ANXIETY, PANIC

____ CONCERN ABOUT ALCOHOL, DRUGS, MEDICATION

____ PERFECTIONISM

____ PHYSICAL STRESS (HEADACHES, UPSET STOMACH, TENSE MUSCLES)

____ ETHNIC / RACIAL CONCERNS

____ CONCERN ABOUT BELIEFS / VALUES

____ SELF-ESTEEM

____ ASSERTIVENESS, SHYNESS

____ DECISION-MAKING ABILITIES

____ RELATIONSHIP WITH EMPLOYER

____ EDUCATION / EMPLOYMENT / CAREER PLANS

____ TEST ANXIETY

____ FINANCIAL MATTERS

____ WORK / EMPLOYMENT

____ DIFFICULTY CONCENTRATING

____ MOTIVATION, PROCRASTINATION

____ DEPRESSION

____ LONELINESS

____ APPETITE CHANGES

____ SLEEP DIFFICULTIES

____ FOOD & BODY IMAGE CONCERNS

____ OTHER HEALTH CONCERNS

____ SUICIDAL THOUGHTS / ACTIONS

____ PHYSICAL ROUGHNESS IN RELATIONSHIPS

PLEASE SUMMARIZE THE SPECIFIC CONCERN THAT BRINGS YOU HERE ____

____

____

____

PARENTS' PREVIOUS OR CURRENT PSYCHOLOGICAL – PSYCHIATRIC – MEDICAL CONDITIONS

PLEASE INDICATE ALL PREVIOUS OR CURRENT CONDITIONS YOU HAVE OR DIAGNOSES YOU HAVE RECEIVED:

- ☐ DEPRESSION
- ☐ BIPOLAR DISORDER
- ☐ GENERAL ANXIETY
- ☐ PANIC ATTACKS
- ☐ OCD
- ☐ SUBSTANCE ABUSE
- ☐ LEARNING DISABILITY
- ☐ SLEEP DISORDER
- ☐ EATING DISORDER
- ☐ PERSONALITY DISORDER
- ☐ VICTIM OF DOMESTIC VIOLENCE
- ☐ VICTIM OF CHILD ABUSE
- ☐ THYROID PROBLEMS
- ☐ ALLERGIES – ASTHMA
- ☐ SEIZURES
- ☐ POST TRAUMATIC STRESS DISORDER
- ☐ ATTENTION DEFICIT HYPERACTIVITY DISORDER
- ☐ PRIOR HEAD TRAUMA OR LOSS OF CONSCIOUSNESS
- ☐ OTHER PSYCHOLOGICAL – PSYCHIATRIC – MEDICAL – OR NEUROLOGICAL CONDITIONS (PLEASE SPECIFY):

Alternative Life Solutions Counseling, PLLC
2458 East Eleventh Street
Odessa, TX 79761
432-582-2444

Welcome to Alternative Life Solutions Counseling and thank you for choosing our services.

Please read this document in its entirety and ask questions about anything that is not clear or you do not fully understand.

This document informs you about the nature of psychotherapy, policies, fees charged, and your rights as a client.

Your signature at the end of this statement indicates your general consent to therapy and agreement to the terms outlined in this form. This is a legally binding contract and the civil courts will hold you accountable to the terms of service.

OUR AGREEMENT:
The therapy process exists to serve you in a manner that is comfortable and appropriate to you. I am working in your interest, and my role is to help you identify and reach your goals. I encourage you at any time to discuss with me any feelings, concerns, or thoughts regarding the methods or policies of your therapy.

QUALIFICATIONS:
The therapists of Alternative Life Solutions Counseling, PLLC have obtained a Master's Degree and are licensed by the Texas State Board of Examiners of Professional Counselors.

Counseling Purposes, Goals, and Techniques:
"Counseling" and "psychotherapy" (therapy) are often used interchangeably to indicate psychological help to address various kinds of personal and family distress e.g., depression, anxiety, and marital conflicts. The goals of therapy often range from the relief of symptoms to significant life change. As you partner with your therapist, through open communication, to explore challenging aspects of your life, it is normal to initially experience uncomfortable feelings e.g., sadness, guilt, anger, frustration, helplessness. Though there are no guarantees, with continued therapeutic work, clients often describe benefits such as greater calmness, vitality, and confidence, a sense of transformation, better relationships, solutions to specific problems, and fewer feelings of distress.

You and your therapist will decide together when your therapy is complete, but you may choose to withdraw at any time. If you decide to withdraw, it is recommended that you have at least one final appointment with your therapist rather than terminating by telephone, mail, or by not showing up.

You will establish the goals for your counseling by discussing with your therapist what you wish to accomplish by your attendance and along with your therapist you will set goals that help determine progress and successful completion of counseling treatment.

The techniques utilized by the therapists at Alternative Life Solutions Counseling, PLLC are eclectic in that each therapist utilizes specific methodology of treatment, also known as school of thought, dependent upon each individual need these may include but may not be limited to:

Biological perspective:
The psychological model behind this school of thought in psychology studies the role of biological functioning to shape the behavior, thus pronouncing the realm of the biological perspective.

Client Name: ______________________________

Psychodynamic perspective:
Sigmund Freud was the founder of psychodynamic approach. This psychological model believes that human behavior is controlled by inner forces over which the individual has little power and has little awareness. This school of thought in psychology lay emphasis on the influence of the unconscious mind on behavior.

Cognitive perspective:
This school of thought in psychology is based on the notion that behavior is controlled by the way we know, comprehend and reflect the world. This branch of psychology studies mental processes including how people think, recognize, remember, and learn.

Behavioral perspective:
This model believes that the external surroundings and environmental causes is the major factor in shaping the behavior of an individual. Behaviorism became the main school of thought in psychology during the 1950s.

Humanistic perspective:
Under to this school of thought in psychology, people have full control over their lives and are solely accountable for shaping their thoughts, ideas, behavior and attitude. This perspective developed as a response to psychoanalysis and behaviorism.

POTENTIAL BENEFITS OF THERAPY:
While no one can guarantee or promise a specific outcome, there are a number of positive outcomes that can result from both short term and long term therapy. Participation in therapy can provide a new perspective on a difficult issue, and can offer new tools to cope with difficulties such as mood and behavior regulation. You may gain better insight into yourself, your relationships, and can find resolution to the concerns that brought you to therapy. The integration of self-awareness can help many individuals better understanding of emotional struggles and lifestyle patterns in order to make positive life choices.
The extent of benefits usually depends on the specific issues or difficulties you hope to address, the goals you have set, and your degree of follow through with treatment. Therapy extends beyond the four walls of my office. Therefore, benefits experienced are often a result of the integration of new insights and skills in between our sessions as well. Psychotherapy requires your very active involvement, honesty, and openness in order to understand and change thoughts, feelings and behaviors that have become barriers. As such, I will ask for your feedback and experience of the therapy process periodically, as we will assess and possibly adjust the treatment plan to meet your therapeutic needs. While there are no guarantees about what benefits therapy will present in your life, some people find that participation in the process can result in changes that were not anticipated, often for the better.

POTENTIAL RISKS OF THERAPY
Like any healthcare service, there are also potential risks associated with therapy. Most risks, if experienced, are direct consequences of positive therapeutic movement. With more attention on the vulnerabilities and areas of dissatisfaction, it is possible to experience increased emotionality. For some clients, this means that *for a time,* they experience discomfort or increased levels of sadness, anxiety, anger, or other unpleasant emotions. If this is to occur, it often happens at the beginning of therapy, and it is usually brought on by an awareness of previously avoided (or even unconscious), emotionally charged material. Significant relationships can be affected by your participation, and it is natural to experience varying degrees of emotionality as a direct result of changes you are making personally. This is most prevalent in romantic & familial relationships, but may extend beyond into one's social and professional life. There is also a risk that therapy may not yield the results that you desired from the outset. Please discuss with me any and all concerns you have regarding potential risks.

Client Name: ________________________________

<u>TERMINATION:</u>

Psychotherapy is voluntary and is time-limited, though varying in duration from one person to another. You have the right to terminate therapy at any time. If you decide to discontinue your therapy prior to completion, you may benefit from having an open and honest conversation with me about your reasons for termination. You have the right to terminate therapy and communication at any time. As a professional clinician, I am ethically required to terminate services with clients who, in my opinion, are outside of my scope of practice or experience. If at any point during psychotherapy I assess that I am not effective in helping you reach the therapeutic goals, or if I have perceived you as non-compliant or non-responsive, I will discuss with you the termination of treatment and conduct pre-termination counseling. In such cases, if appropriate, I will give you referrals to qualified professionals whose services you might prefer.

<u>FEES AND PAYMENT</u>:

Each therapist at Alternative Life Solutions Counseling, PLLC is in private practice and sets their own fees. Generally rates are as follows:

Initial session 53-60 minutes -$300.00; Continuing 53-60 minute sessions - $120.00 for individuals and $140.00 for couples or family; 45-52 minute sessions - $100.00 for individuals.

Insurance is filed as a matter of convenience for you and is becoming widely not used by therapist and you are given a form to submit to your insurance. It the event your insurance does not pay for services you will be held fully accountable for the unpaid balance. Failure to pay will result in your account being turned over to our collections agency or filed in Civil Courts for legal proceedings for collection. If you choose not to agree to this policy we will be happy to provide you with the forms to file with your insurance and full payment will be required at the time of service.

<u>Your therapist may adjust your fee, based on need, if you provide proper documentation</u>. Please be sure to discuss this at the start of your initial session and fees will be set and agreed upon in writing at that time. Payment is due at the time of your appointment.

By signing below, you accept financial responsibility for all services received. Payment for service is due at the end of each session. Fees may change over time, but you will be informed of any potential rate increases well in advance. I accept cash, Visa, MasterCard, Discover, American Express, HSA, and Flex account expense credit card.

____ Full Signature and date signed _______________

Client Name ___________________________________

CONFIDENTIALITY:

What you tell your therapist will be kept confidential and will not be revealed without your written permission, except when mandated by state and federal statutes, court order, or as part of the professional and administrative practice of this Group. Texas state law and the ethics of professional counseling require that anything you say in the context of our therapeutic relationship and the written records pertaining to those sessions are confidential and may not be revealed to anyone without the identified client's written permission except where disclosure is required by law. There are legal limits to confidentiality and times when a licensed professional is obligated to disclose pertinent information, as necessary, to the appropriate authorities/agencies/individuals such as:

1. If your therapist suspects you pose a harm to yourself or others.
2. If you report that a child, elderly person, or anyone else who cannot otherwise protect themselves has or is being neglected, or physically or sexually abused.
3. If there is an ordered disclosure by state or federal courts.
4. If a complaint is filed with the licensing board it shall be understood that all records and information regarding treatment and all documentation needed by the Board and the attorneys representing both parties and/or the State Licensing Board will be open for full disclosure of all information obtained during the counseling process. This also applies to any civil or legal proceedings involving the therapist and plaintiff. All rights to confidentiality are forfeited.

You will be given a copy of the Notices of Privacy Practices

Alternative Life Solutions Counseling, PLLC contracted therapists maintains client records on an encrypted off site database through Therapy Appointment. All records will be maintained in this secured environment at all times. In the event of the untimely death or incapacity of the therapist, unexpected closure of the practice or the support staff will advise current and past clients of the procedures to obtain the records for client's new therapist. All records are maintained for a period of seven years for adults or seven years past the 18th birthday for children.

INSURANCE AND OTHER THIRD-PARTY PAYMENTS:

If your therapist accepts third party reimbursement from insurance companies and you wish to use insurance or other third-party coverage (e.g., a managed care organization or employee assistance program) to pay for therapy, you are responsible for providing Alternative Life Solutions Counseling with accurate and complete information by completing the "insurance information" section of the *Client Information* form. Alternative Life Solutions Counseling, PLLC does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by your insurance or third party payer. Sometimes the insurance company limits the number of sessions they will provide coverage for. If you choose to continue sessions with your therapist beyond those provided by the insurance company, you are agreeing to pay your co-pay plus the amount that your insurance company normally pays.

Client Name ________________________________

INSURANCE AND CONFIDENTIALITY:
If you use your health insurance to pay for therapy, your insurance company requires that your therapist provide information relevant to the services you receive. This includes a clinical diagnosis and treatment plans, which will become a part of the insurance company files.

APPOINTMENTS AND CANCELLATIONS:

You will be charged a full regular fee for any appointment that you miss or cancel with less than 24 hours' notice. If you are using your insurance, this charge is **not** covered by insurance, so you will owe the total of what your insurance would have paid plus your co-pay or deductible. If you do not use insurance your charge will equal your regular session fee. We prefer 48-hour notice of cancellation so that someone else may take that appointment time. **Notice: Due to the waiting list for individuals and families seeking counseling** t is very important to keep your scheduled appointments as part of being devoted to making progress toward your goals. There is generally a waiting list to schedule appointments so not showing up for your appointment also prevents someone from being scheduled at that time if you would have cancelled at least 24 hours in advance. **Special rules apply. You are allowed one cancel and must be 24 hours before your appointment. You are allowed one no show. If you fail to attend your session without 24 hours notice then you will be referred to a different counseling agency. Prompt and consistent appointments are required for treatment you will be charged a full fee and you will be released from our services and referred to another agency. If you are more than ten minutes late for your appointment you will be charged for a missed appointment and required to reschedule your appointment. More than two late appointments you will be referred to another agency. Remember, counseling is a commitment to making changes in your life. The first step is committing to your treatment and following you agreement to make changes. Therefore, a strict appointment policy is for the betterment of your treatment. We have many patients on a wait list that are wanting to be dedicated to change, therefore we must enforce a strict attendance policy. Thank you for your understanding.**

________________________________ Your Signature and Date: ________________________

LEGAL PROCEEDINGS:
The therapists at Alternative Life Solutions Counseling, PLLC, do not provide testimony in legal proceedings. If you choose to subpoena your therapist or your records, however, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at a charge equal to the therapist's legal proceedings hourly rate of $500 per hour. By initialing you agree that the total fee of $500 per hour will include all time for the therapist to prepare documentation needed for court, prepare for testimony, consult with the attorney, travel time and waiting time. You will be responsible for paying an estimated time use upfront. **A subpoena does NOT excuse you from paying for services and failure to do so will result in your therapist contacting the court advising you have not paid for services and the court may choose to postpone your legal proceeding.** The judge and your attorney as well as the prosecutor will be given a copy of this contractual agreement. The therapist may also file a claim of non-payment in civil court. Insurance does not cover legal testimony and will not be billed. By initialing you agree that you have read and understand and agree to this policy. ***You will be charged a minimum fee of $1600 prior to any court preparations.*** This full fee must be paid prior to court, and the day a subpoena is served or ten days prior to the court date if no subpoena is served.

Client Name ________________________________

The client also agrees that they agree to release the therapist from duty as their therapist and terminate our therapeutic relationship. By initialing and signing this treatment contract you also agree that the judge may order full disclosure of all treatment notes and issues if requested by your attorney, the prosecutor or other civil court attorney. If a judge orders testimony, you will be subject to full disclosure of all information provided in sessions or otherwise in accordance with Texas Code of Criminal Procedures, The Texas Licensed Professional Counselors Board or the Texas Council on Sex Offender treatment.

____ Your Full Signature and Date __________

Contacting Your Therapist:
Appointments may be scheduled in person, over the phone, via text, or via email. Email and text communication is ONLY used for arranging appointments. I will not engage in discussions regarding your treatment using these means. Telephone sessions may be arranged, but my usual fee will be applied. _____Initals

EMERGENCIES:

Alternative Life Solutions Counseling, PLLC nor any of the contracted therapists **does not provide "emergency services"**. If you have an urgent concern, we try to schedule an appointment as soon as possible. If you have a critical emergency, contact the 24-hour MHMR Hotline (432) 333-3265 or 911. After-hours messages can be left on the Alternative Life Solutions Counseling, PLLC voice- mail system, but do not leave an urgent message since these messages may not be reviewed until the next business day._________ Initial

CONSUMER COMPLAINT HOTLINES:
Licensed Professional Counselors: (512) 305-7700, 333 Guadalupe St, Tower 3, Room 900, Austin, TX 78701
Licensed Sex Offender Treatment Providers (800) 942-5540, Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369.

Client Consent and Agreement:

In signing this document, I agree that:
The information contained in the Client Agreement and Consent form was made available to me, explained to or read by me and that I was able to ask questions about this agreement.

I understand that therapists at Alternative Life Solutions Counseling are contracted therapists and **are not employees** of Alternative Life Solutions Counseling, PLLC and each individual therapists is considered to be a private practice practitioner contracted to provide services at Alternative Life Solutions Counseling, PLLC, therefore any complaints regarding a therapists need to be reported through the complaint process at the telephone number noted above. If you feel that you wish to change therapists you may request to do so and you will be provided the option of seeing a different therapist at Alternative Life Solutions Counseling or referred to another agency.

Client Name________________________________

- I consent and voluntarily enter into therapy with __________________________________, a therapist at Alternative Life Solutions Counseling, PLLC.
- I may withdraw from treatment at any time (unless treatment is court ordered), if;
  - I am 18 years of age or over and have not been declared incompetent by a court of law, or;
  - I am the parent/legally-appointed guardian or other authorized representative of the client to be treated, if such client is 17 or younger, or;
  - Although under 18 years of age, I am legally empowered to consent to treatment per the conditions outlined in the Texas Family Code.
- I am financially responsible to Alternative Life Solutions Counseling, PLLC as described in the Client Agreement and Consent Form for services and treatment rendered to the client named in this consent.
- I understand therapy is a joint endeavor between the therapist and client, and specific results are not guaranteed.
- I will be informed if my therapist believes counseling is not appropriate for my circumstances or that I should be referred elsewhere.
- I understand that effective counseling involves my attending regularly scheduled counseling appointments and talking openly with my therapist.
- My therapist has informed me of any possible risks in my seeking therapy or terminating therapy and will work with me in determining the best course of treatment.
- 1 understand my right to have any tests, procedures, and recommendations explained to me in simple terms, and I have the right to refuse such tests, procedures, or recommendations.
- If applicable, I have been informed that my therapist, _________________ is a Therapist in Training.

By signing, I agree that I have read the informed consent in its entirety and if I did not understand any portion of the entire document that I have discussed this with my therapist so there is no confusion about the intent or meaning of all information. I also agree to the terms of financial responsibility and cancellation procedures.

____
Printed Name of Client

____
Signature of Client Date

Social/Electronic Media Policy
My Private Practice Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING/FOLLOWING
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Linkedln, etc) or follow any clients on Twitter. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

INTERACTING
Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or Linkedln to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

USE OF SEARCH ENGINES
It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

GOOGLE READER
I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

BUSINESS REVIEW SITES
You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

LOCATION-BASED SERVICES
If you use location-based services on your mobile phone, please be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone, as this may compromise your confidentiality.

EMAIL
I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CONCLUSION

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Your signature below indicates your understanding and acceptance of this policy, and your willingness to abide by its terms and limitations.

____

Signature of Client

Alternative Life Solutions Counseling, PLLC
2458 East Eleventh Street
Odessa, TX 79761

Electronic Data Communication Consent

It is very important that you are aware that computer, email, text, fax, or phone communication can be accessed by unauthorized people, and can hence compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular are vulnerable to such unauthorized access due to the fact that internet servers and communication companies may have unlimited and direct access to all email, texts, faxes that goes through them. If you choose to allow confidential communication via email, text, fax, or phone, you should have a thorough understanding and knowledge of the security and privacy vulnerabilities of the system on which you access it.

While data on Alternative Life Solutions Counseling, PLLC therapists' computer is encrypted, most email is not. It is always a possibility that email, texts, e-faxes, and voicemail can be sent to the wrong address, phone and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your healthcare provider that you would not want to be included on a post card that is sent through the Post Office. E-mail messages on your computer, laptop, iPad, tablet, phone or other electronic devices have inherent privacy risks— especially when your email is provided through your employer or when access to your email is not privacy protected.

All of the e-mails Alternative Life Solutions Counseling contracted therapists sends and receives is accessed and stored on a password- protected laptop that is equipped with a firewall and virus protection. All confidential information from the computer is backed up on a regular basis onto an encrypted hard drive. Please note that e-mails, faxes, and texts are all part of your clinical record. Please notify your therapist if you decide to avoid or limit in any way, the use of electronic communication via e-mail, text, fax, phone calls or phone messages. If you communicate confidential or private information via unencrypted e-mail, text, fax, or phone messages, it will be assumed that you have evaluated the risks and made an informed decision and your therapist will understand this as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored.

DO not use e-mail, text, fax, or voicemail for emergencies.

By providing my email address below or phone number for texting, I am hereby offering consent for my therapist to use email, text, fax, and phone messages to communicate with me between sessions. I have read this document and I understand and hereby accept the privacy risks associated with the use of e-mail, text, fax or phone. I also understand that Alternative Life Solutions Counseling or their therapists cannot be held liable for breaches of security by another party.

E-mail address: ____

Cell phone number: _____________________________________

Client's Printed Name: ___________________________________

Client's Signature: ______________________________________

Date Signed: _________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
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 we 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.

We are 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. We are required to abide by the terms of this Notice of Privacy Practices. We 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. We 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:

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. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. 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. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

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

Abuse and Neglect
Emergencies
National Security
Judicial and Administrative Proceedings
Law Enforcement

<u>Without Authorization.</u> Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

<u>With Authorization.</u> Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Alternative Life Solutions Counseling, PLLC.

- **Right of Access 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.
- **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 we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **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. We are not required to agree to your 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.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- **Electronic Transactions Standards.**

Alternative Life Solutions Counseling, PLLC
2458 East 11th Street
Odessa, TX 79761
432-582-2444

I have received and was given a copy of the Notice Of Privacy Acts for Alternative Life Solutions Counseling.

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Signature Date

____
Printed Name