HOUSTON CENTER FOR MENTAL HEALTH AND DEAFNESS

Gabriel I. Lomas, Ph.D., LPC
Owner

Paul B. Damin, Ph.D.
Psychologist

Jennifer S. Freundel, M.A., LPC
Psychotherapist

Amanda Ramirez, M.A., LPC Intern
Psychotherapist Intern

Helen Swiff-Goodman, M.A., Psy.S.
Specialist in School Psychology

Leisha Campbell, M.Ed., LPC Intern
Psychotherapist Intern

INFORMED CONSENT FOR SERVICES

Dear Client:

Welcome to your initial session. I have prepared an explanation to help you understand what you can expect. I have also prepared information about fees and procedures. Being an informed client is important. In an effort to ensure that you understand the limits of confidentiality that apply to you, please read the following carefully and ask any questions you might have about the services.

CONFIDENTIALITY Keeping your records confidential is of highest priority. Office staff have been trained regarding issues of confidentiality. Any special circumstances or conditions related to your case will be discussed in the initial sessions or when such information becomes relevant. Any part of your record will be sent only *with your written permission* or by someone with legal authority to give such permission. Exceptions to confidentiality include:

1. If you threaten to harm yourself or another person, I have a duty to protect you from yourself or another person from you. Relevant information will be released, only to individuals or officials who could reasonably be expected to prevent your intended action.

2. If you say that you abused or are abusing a child, elderly person, or disabled person, I am required to report to a designated local agency for action.

3. If your records or therapist's testimony are subpoenaed for court proceedings.

3701 Kirby Drive, Suite 1014, Houston, TX 77098
713-533-9778 (p) | 713-522-6308
Lomasg@Comcast.Net | www.HCMHD.ORG

APPOINTMENTS Situations may arise that make it impossible to keep a scheduled appointment. If you must cancel an appointment, give at least 24 hours notice by telephone or by Friday noon for Monday appointments. You may also use email to cancel your appointment. Failure to cancel appointments under these guidelines will result in being charged full fee for the appointment. Compelling reasons for later cancellations will be considered on a case-by-case basis to avoid charges. No-shows (appointments made and not canceled) will be charged at full rates. Sessions are generally 45-50 minutes in length; group sessions are 60 to 90 minutes. If you are late in arriving for your appointment, you will be seen within the time period remaining for your scheduled session. If your sessions are contracted with an agency that reimburses for your treatment, repeated cancellations or no-shows can result in termination of services, as your appointment time is scheduled for you and no other clients.

FEES The full fee is due at the time of service unless other arrangements are made in advance. Failure of insurance companies or other third parties not paying as expected is disappointing. However, the ultimate responsibility for payment is with the client. Please be aware that fees not paid are subject to submission to a collection service.

When I accept you as a client, it was because your concern was within the scope of my training and experience, and that I could be of assistance to you. It is my professional obligation to practice within this framework, as well as to observe the ethics and standard of care of my profession. My pledge is to provide the best service I can. Despite both of our best efforts, however, results of treatment cannot be guaranteed.

I hope this information is helpful to you. Your signature on this page indicates that your have read, understood, and asked questions about this explanation of services. Further, your signature indicates agreements with the terms set forth above.

____________________________	____________________________
Printed Client Name or Name of Minor	Client or Parent/Guardian Signature

____

Date

I have answered all questions asked of me by the above client(s).

____________________________	____________________________
HCMHD Representative	Date

CONSENT FOR E-MAIL AND VIDEO PHONE COMMUNICATION

I am requesting that personnel from: Houston Center for Mental Health and Deafness (HCMHD), hereafter referred to as my mental health provider to use the following approved method(s) for communicating with me on my therapeutic and/or medical needs.

A. Email

____ do not contact me through email; or ____ contact me using e-mail at the following:

____.

B. Video Phone

____ do not contact me through video phone;

or

____ contact me through video phone at: ____________________________________.

I understand that these e-mail and video phone transmissions may contain protected health information (PHI) and that what I have listed does not necessarily meet the security requirements normally used to protect the confidentiality of my protected health information. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. I understand my mental health provider will use the minimum necessary amount of protected health information to respond to my query and/or provide services.

I am aware that there are free programs which would permit me to encrypt my e-mails, making them more secure, but I would prefer to use the addresses identified above. I also understand that I should not store the e-mails received from my mental health provider on my home computer. I also understand that e-mail is not for emergency services and that it may be the next business day or longer before my e-mail will be read.

I understand that my health care provider may use email to communicate with colleagues and agencies regarding my case.

I may revoke this permission at any time by notifying my mental health provider.

____ ______________________
Client/Guardian Date

The staff person who has co-signed this document with me has explained fully the consequences of signing this waiver and I understand what it means. Further, I release the staff/agency from any liability in regards to using the methods of communication as above.

____________________________ ____________________________
Client/Guardian Mental Health Professional

____________________________ ____________________________
Date Date