FACESHEET: **TELECOUNSELOR.CLINIC** **JOSEPH CENTER**

Joseph D. LaBeau, M.Ed., LPC

Patient Last Name- *Apellido -*	**First Name** *Nombre*	**Middle Name**
Date of Birth *Fecha de Nacimiento*	**TELEPHONE**	
EMERGENCY CONTACT: *NAME:*	**Telephone***:* *RELATIONSHIP:*	

PARENT/SPOUSE/ GUARANTOR/ RESPONSIBLE PARTY Garante/Persona Responsible

Name *Nombre de Padres o Guardias*	**Relationship to Patient** *Relacion a paciente*		**Telephone** *Telefono*	
ADDRESS *Referido por*		**Telephone** *Telefono*		
Marital Status	**□Single □Married** *Soltero(a) Casado(a)*	**□Divorced** *Divorciado(a)*	**□Widowed** *Viudo(a)*	**□Separated** *Separado(a)*
□Student *Estudiatne*	**□Not Employed** *No Empleado*	**□Employed** *Empleado*	**□Retired** *Jubilado*	**□Other** *Otro*
Employer *Empleador*	**Address** *Direcion*		**Telephone** *Telefono*	

INSURANCE ASSIGNMENT

Medicaid #_____ COMPANY_____

PRIVATE INSURANCE INFORMATION *(If applicable, please complete)* ***Seguranza Primario***

Name of Insured *Nombre del asegurado*	**Date of Birth** *Fecha del Nacimiento*	**Social Security Number** *Numero de Seguro Social*
Name of PRIMARY Insurance *Nombre de la Seguranza*		**Insurance Phone #** *Telefono de Aseguro*
Policy Number *Numero de Poliza*		**Group Number** *Numero de Grupo*

SECONDARY INSURANCE INFORMATION ***(If applicable, please complete)*** ***Seguranza Secundario***

Name of Insured	**Date of Birth**	**Social Security Number**
Nombre del asegurado	*Feccha del Nacimiento*	*Numero de Seguro Social*
Name of SECONDARY Insurance		**Insurance Phone #**
Nombre de la Seguranza		*Telefono de Aseguro*
Policy Number		**Group Number**
Numero de Poliza		*Numero de Grupo*

I certify that I have answered all questions to the best of my knowledge. I assigned directly to Joseph LaBeau, LPC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorize Joseph LaBeau, LPC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission. I also specifically authorize Joseph LaBeau or his representative to call the telephone numbers listed above and to leave messages with any person who may answer, or with answering machines or recording devices, such messages may include the name of the patient, and the status, date, and time of appointments. Certifico que he contestado todas las preguntas segun mi mejor conocimiento. Directamente segun a la oficina de Joseph LaBeau, LPC todos los beneficios de mi seguranza por los servicios rendidos. Entiendo que yo soy personalmente responsable por cualquier pago no pagado por mi seguranza. ***Yo autorizo que la clinica utilice la informacion necesaria para asegurar el pago de los beneficios de mi seguranza. Afirmo el uso de mi firma para sumision de mis datos a la seguranza***

The notice of Private Practices was provided to me to read according to the HIPAA (Health Insurance Portability and Accountability Act) regulations

La Nueva ley de la Privacidad de mi informacion medica fue ofrecida para mi lectura de acuerdo con las regulaciones de HIPAA (Health Insurance Portability and Accountability Act.

Texas LPC Required Notices:

(1) Fees and arrangements for payments: See separate document, Financial Policy and Agreement.

(2) Counseling purposes are to increase adjustment, coping ability, and personal growth. Goals include reducing symptoms, increasing self control, self esteem, assertiveness, and restoring life/ work/school function and satisfaction and completing developmental tasks. Techniques include building a therapeutic relationship, free association, analysis and interpretation of dreams, fantasies, wishes, images, thoughts, beliefs, behaviors, feelings, memories, and defenses; ego strengthening by mirroring, reflecting, and joining; hypnotic suggestion, modeling, behavioral tasks and experiments, and psychological education and instruction.

3) Restrictions placed on the license by the board; None

(4) Confidentiality limits; Information concerning this therapy will not be disclosed without your prior written permission, except for when a.) You or a session participant is a danger to self or others. b.) A lawful court order is issued and/or law enforcement personnel lawfully demand information about criminal matters excluded from confidentiality protection. c.) There is reasonable suspicion of abuse of a child or vulnerable adult.

d.) In couples or group settings of any kind, confidentially cannot be guaranteed amongst or between participants neither inside nor outside sessions. Your counselor can only promise qualified confidentiality (within the limits of this handout) outside of sessions with non-participants.

e.) Telecommunication presents special confidentiality risks. These include- insecure client devices/computers (some networks/apps/utilities, etc., may be listening in and should be disabled prior to sessions, clients alone are responsible for ensuring password /device security so that an impostor does not breach security), insecure client settings (clients must ensure that they and only they and officially invited and declared session guests are admitted to the private setting/room they are using and that there are no listeners at the door, etc). In sum, these and other

confidentiality risks are inherent in the telecommunication system and the client assumes total responsibility for these risks of confidentiality breaches outside of those managed by the Hippa Compliant Tele-communication Services managed by Therapy Sites.

f.) An insurance benefit is filed and the claims payer requires disclosure of information, i.e., diagnosis, types of treatment, dates, symptoms, prognosis, progress etc., to evaluate coverage or continuance of coverage. f.) I may sometimes ask the professional opinion of other medical professionals about treatment.. I will not unnecessarily reveal identifying information. g.) In the event your account is turned over to a bill collector or is the subject of a lawsuit, your personal information and some treatment information may be publicly disclosed.

(5) Intent of the licensee to use another individual to provide counseling services to the client; NONE.

(6) Supervision of the licensee by another licensed health care professional NONE

(7) The name, address and telephone number of the board for the purpose of reporting violations; State Board of Professional Counselors 1100 W. 49th, Austin, TX. 7856-3183 Phone (512) 834-6658

(8) Plan for the custody and control of the client's mental health records in the event of the licensee's death or incapacity, or the termination of the licensee's counseling practice. Should therapist die or become incapacitated, requests for records may be made by authorized persons only by mail to the extant physical address for the Joseph Center. Appropriate requests will be honored for 90 days after therapist incapacitation. Thereafter, correspondence will be returned unopened**.**

HIPPA: Notice Of Privacy Practices: As required by the privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE

HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHl). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHl. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Joseph LaBeau, M. Ed., LPC

1429 Tucker Rd., Harlingen, TX 78552

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY TDENTIFIABLE HEALTH

TNFORMATTON (PHl) lN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription

for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose youi PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN GERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- reporting abuse, neglect, or family and intimate partner violence
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- reporting reactions to drugs or medical devices
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease
- notifying your employer under limited circumstances related primarily to workplace injury or

illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar proceedings. Our practice may use or disclose your PHI in response to a court or administrative order. We may also disclose PHI in response to a discovery request, subpoena, or other lawful process. We are required to make an effort to inform you of such requests.

4. Law Enforcement. We may release PHI to a law enforcement official if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal misconduct
- Regarding criminal conduct in our offices or in virtual, on-line meeting.
- In response to a warrant, summons, court order, subpoena or similar process.
- To identify a suspect, Material witness, fugitive, or missing person
- In an emergency to report a crime, including the location and victims of the crime, and the description, identity or location of the perpetrator.

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. lf necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an IRB or Privacy Board has determined. that the waiver of your authorization satisfies the following. (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHl.

8. Serious Threats to Health or Safety. Our practice may use and disclose your-PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11-Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to JOSEPH LABEAU, LPC specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. ln order to request a restriction in our use or disclosure of your PHl, you must make your request in writing to JOSEPH LABEAU, LPC

Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to JOSEPH LABEAU, LPC in order to inspect and/or obtain a copy of your PHl. Our practice may charge a fee for the cost of copying and mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kepi by or for our practice. To request an amendment, your request must be made in writing and submitted to JOSEPH LABEAU, LPC. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the

information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Joseph LaBeau, LPC. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14,2003.

The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Joseph LaBeau, LPC.

7. Right to File a Complaint. lf you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of t-he Department of Health and Human

Services. To file a complaint with our practice, contact JOSEPH LABEAU, LPC. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies,

please contact JOSEPH LABEAU, LPC, 1429 Tucker Rd., Harlingen, TX 78552

Special Notices Regarding Telehealth Services:

1. I understand that telehealth is the use of electronic information and communication technology to deliver health care services including, but not limited to, the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient, when the patient is located at a different site than the provider.

2. I understand that my health care provider wishes me to engage in a telehealth consultation.

3. My health care provider has explained to me how the electronic information and communication technology will be used during the consultation and will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties that may lead to an inability to obtain information sufficient for decision making about my health problem and that all reasonable precautions will be taken to minimize these risks. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the technology is not adequate for the situation.

5. I am aware that telehealth is not an emergency service and that local emergency service providers should be contacted in the case of a mental health crisis or emergency.

6. I am aware that alternatives to telehealth include face to face consultation with a provider who performs that service and that for reasons of distance, health, and other prohibiting factors, my current telehealth provider may not be able to provide face to face services, but in such case, will refer me to sources of care or sources of referral for care.

7. I understand that my healthcare information may be shared with other individuals for treatment, payment or operations purposes, in accordance with Texas State and Federal Privacy rules and the above REQUIRED NOTICES, number 4.

8. My questions have been answered and the risks and any practical alternatives have been discussed with me in a language in which I understand.

9. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time.

10. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

11. I understand that I have the right to select another provider and am aware that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

Fee Schedule, Financial Policy And Agreement

INSURANCE/OTHER: The Joseph Center does not generally accept insurance. Upon specific case mutual agreement, we will work with your insurance company and accept the contracted insurance payment rate from them and bill them on your behalf; however, ALL PAYMENTS FOR SERVICES NOT COVERED BY INSURANCE, SUCH AS CO-PAYS, TELE-HEALTH, TEST FEES, ETC. are due in full at time of service and may be made by cash or credit card.

NOTICE: TELE-HEALTH SESSIONS /SERVICES NOT COVERED BY INSURANCE MUST BE PAID BY THE CLIENT OR CLIENT RESPONSIBLE PARTY.

FEE SCHEDULE:

INDIVIDUAL AND COUPLE SESSIONS, Face to Face or Tele-health (up to 45 MINUTES) and MISSED APPOINTMENTS **$90** (Missed Appointment fee is charged to credit card immediately after missed session. No Missed Appointment fee charged if bone fide emergency or 24 hrs advance notice provided)

TEXT / ASYNCHRONOUS CONSULTATION: **$30** (instead of above $90 fee) per session.

RECORD COPY FEE: First page $25 (.50 per page thereafter)

EXTENDED CONSULTATION FEE: (EACH 15 MINUTES AFTER THE FIRST) $25.

COURT FEE SCHEDULE: Court Appearance for any related case (each 15 minutes, including travel time) $25. Business Disruption fee of $25 for each appointment cancelled with less than two weeks notice due to untimely notice of subpoena. LETTERS, REPORTS, etc. $100/hr., minimum fee for each document: $50

FINAL RESPONSIBILITY FOR PAYMENT IS YOURS. ANY UNPAID AMOUNT AFTER 30 DAYS WILL BE BILLED TO YOU AND IS PAYABLE BY YOU. ACCOUNTS WITH AMOUNTS DUE LONGER THAN 60 DAYS MAY BE RECOVERED BY A DEBT COLLECTION AGENCY OR PUBLIC LAWSUIT RESULTING IN ADVERSE IMPACT ON YOUR CREDIT RATING.

CREDIT CARD ON FILE AGREEMENT

Unless prior arrangements have been made, if for any reason you should have a balance that is 60 days past due, we will automatically charge the balance to your credit card on file.

CONSENT AND ATTESTATION

I have read and understand and accept the above **Required Notices and separate document Fee Schedule and Financial Policy and Agreement and Notice of Privacy.** Also, I give full consent for the completion of treatment and psychotherapy for the patient named above and myself and my other family members in family sessions. I further hereby attest that no child, neither a child named above, nor any other child brought into ANY sessions are named in a custody order or decree, unless that order or decree permits such participation and a copy has been provided to the counselor. Also, I hereby authorize, Joseph La Beau, M.Ed., LPC Joseph Center 1429 Tucker Rd. Harlingen Texas 78552 to release all chart** information and consultation information, verbal and written, inclusive of substance abuse information and exclusive of HIV/AIDS information, to my physician: N/A unless otherwise designated_____ for the purpose of continuity of care, I understand that I can revoke this authorization at any time by written notice and that this authorization will expire in one year from the date below. Finally, I waive my right to privacy of protected health information (PHI) for email transmission of PHI for above purposes and for telephone messages regarding appointments, and request that voice and text messages be left for me by text, voicemail, recording, etc., or with other persons who may answer on my behalf, on the telephone number provided above.:

Signature ***Firma***	**Date** ***Fecha***
Relationship to Patient ***Relacion al Paciente***	