Empowerment Psychological Services, PLLC

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INFORMED CONSENT FOR SERVICES

Welcome to my practice. Please read carefully as this document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between you and me.

Psychological Services

The therapy process is a partnership between you and the psychologist to work on areas of concern in your life, develop growth and insight, and improve your overall well-being. For therapy to be effective, it is necessary for both of us to take an active role in this process. Participation involves being open to the psychologist's thoughts and ideas, being honest with your psychologist, completing outside assignments, and providing ongoing feedback about the process.

Psychotherapy can have benefits and risks. Because therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, loneliness, and helplessness. However, through this challenging work, many benefits can be experienced, such as improved relationships, decreased distress, and solutions to specific problems. For you to maximize your experience, it is helpful to discuss any questions or discomfort you may experience during the therapeutic process. I will work to help you understand the experience and/or use different methods or techniques that may lead you towards the growth you desire.

You have the right to decide not to enter therapy with me. If you feel that you are not making progress towards your goals, you may terminate the therapeutic relationship at any time. I will provide you with a list of referrals for therapists in the community. To help you transition, I may request one last formalized session, so you can provide feedback and consider your next steps.

Sessions

I typically conduct an ongoing evaluation over the first several sessions. During this time, we can both decide if I am the best person to provide services you need to meet your treatment goals. Once we begin psychotherapy, we will most likely schedule one 50 minute session per week, although some sessions may be longer or more frequent depending on the nature of the treatment. We may re-evaluate the frequency of your sessions as situations arise and/or as you move towards your goals. All therapy sessions will be conducted via HIPAA compliant video conference platform.

Cancellations

Therapy is most effective when an individual attends appointment on time and in a consistent manner. You are urged to be on time. You are required to cancel your appointment at least 24 hours in advance to avoid cancellation fee. If, for any reason, you cannot let me know at least 24 hours in advance, you will be charged the regular cancelation fee. If your appointment is rescheduled for the same week without at least a 24 hours

notice, you will still be charged for the reserved time. Insurance companies will not pay for no-show/cancellation charges.

Fees

Therapy is a personal investment in one's growth and overall well-being. You are expected to pay for the client portion of fees at the time of service. The standard fees for service are as follows:

You are responsible for any unpaid portions after insurance. Limited sliding scale fees are available for current clients experiencing financial strain with proper documentation. Sliding scale fees are subject to increase at any time and the discount will be terminated if the client is not consistent with appointments.

Payment can be made with **Simple Practice via credit card, PayPal, Zelle, Venmo, cash or a personal check**. I am contracted with **Blue Cross Blue Shield** and **United Healthcare**. Coverage varies greatly between plans, please reach out to your provider directly to verify coverage details. If insurance declines to cover your visit(s) for any reason, you are responsible for the full amount billed. If you have insurance coverage from another provider, I will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim at the end of each session or month. Accounts become delinquent after (30) days of nonpayment. Accounts more than 90 days in arrears will be terminated.

Assignments of Benefits

I assign directly to Empowerment Psychological Services., PLLC all insurance benefits, if, any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges not paid by my insurance as well as collection fees or interest that may be added if the account should be placed with an outside collection agency. I authorize the use of my signature on all insurance submissions. The above name facility may use my healthcare information and may disclose such information to the named insurance company or companies and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

Contacting Me

I recognize situations may arise, and you may want to speak with me via telephone in between sessions. You are welcome to contact me by phone and may leave non-urgent, non-emergency messages with date, time and telephone number and your call will be answered when I am available during office hours.

In the event of an emergency, please contact 911, or you may call the Crisis Intervention of Houston Hotline at (713) 468-5463, the 24 hour Mental Health Crisis 1-800-273- 8255, 1-800-SUICIDE (1-800-784-2433) Line or go to your local Emergency Room for immediate assistance.

Email/Text: Although e-mail and text messaging have become a major means of communication between individuals, these forms of communication have significant limitations. As such, you may communicate via e-mail or text messaging for issues regarding scheduling or cancellations only. Please be aware any email and text exchanges become a part of your clinical record.

Confidentiality

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information to others about your treatment if you sign a release of information / written authorization form. There are certain circumstances, however, when a psychologist is required to disclose

confidential information without consent/authorization from patients. These circumstances include, but are not limited to:

a. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her and/or contact family members or others who can help provide protection.

b. If a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include contacting the police or seeking hospitalization for the patient.

c. If I believe a child, disabled adult, or elderly person has been abused, neglected or exploited, the law requires I file a report with the appropriate state agency within 48 hours. Once a report is filed, I may be required to provide additional information.

d. If a complaint or legal action is filed against me or the practice, I may disclose relevant information regarding that patient to defend myself.

e. If a patient is involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist/patient privilege law. I cannot provide any information without written authorization from you, a legally appointed representative, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

Additionally, I may occasionally find it helpful to consult other health and mental health professionals about a case. During our consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your clinical record.

Professional Records

Pursuant to HIPAA, I keep Protected Health Information (PHI) about you in your clinical records. Your record contains information including: your reasons for seeking therapy, a description of the ways in which your problem impacts your life, diagnosis, goals we set for treatment, progress toward those goals, medical history, social history, treatment records I receive from other providers, reports of any professional consultations.

Your clinical record will not be released without your written authorization, except in the situations described under Confidentiality. An "authorization" is a written permission above the general consent form you are signing today. In those instances when I'm asked for information for purposes outside of treatment/evaluation, I will obtain a release of information/written authorization from you before releasing any information. I cannot release information about you or a minor (e.g., to schools, employers, family members other care providers, etc.) without direct written authorization from client or legal guardian allowing for release of client information.

Upon request, you will be asked to arrange an appointment to review the information in my presence so we can discuss the contents. You reserve the right to request corrections or additions to your records. You may be charged a full or partial session fee for administrative costs/time related to getting copies of your records. Counseling records are maintained for 10 years after your last contact with me.

Records are stored in a record-keeping system produced and maintained by SimplePractice, LLC. This system is "cloud-based," meaning the records are stored on servers, which are connected to the Internet. SimplePractice, LLC employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure. SimplePractice, LLC is HIPAA-compliant. All data is hosted on a Tier 1 secure hosting provider, and the servers are housed in a secured facility protected by proximity readers, biometric scanners, and security guards. You can read more at https://www.simplepractice.com/security/.

CONSENT FOR SERVICES

By signing below, I acknowledge that I have read, understand, and accept the information and policies presented above. I agree to abide to the terms of this consent form and to receive services from Empowerment Psychological Services, PLLC.

_____ _____

Name of Patient/ Guardian Date of Birth

_____ _____

Patient/Guardian Signature Date

_____

Piero Peirano, Psy.D
Licensed Clinical Psychologist
Empowerment Psychological Services, PLLC