KThomas Counseling Services

Kimberly Thomas, LPC
26139 Lost Creek Way, Boerne, TX 78015
Office 830-431-2290 Fax 844-222-7112
NPI – 1063009462 TPI – 420007301 License #81751

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal, and I am committed to protecting health information about you. A record of the care and services you receive from me will be created to ensure you are provided with quality care and to ensure KThomas Counseling Services and its subsidiaries comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which your health information is used and/or disclosed. This document further describes your rights to the health information kept about you, and describes certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") identifying you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- Inform you that changes to the terms of this Notice and the resulting changes themselves apply to all information I have about you. Any change in this notice will be available upon request.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways your health information is used and/or disclosed.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information if a consultation with another health professional is deemed necessary. I have the responsibility in such a case to disclose only what is necessary.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to a client's full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I am bound by law to disclose health information in response to a court or administrative order. I am also bound to disclose health information about a minor client in response to a subpoena, discovery request, or other lawful process.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

Psychotherapy Notes—I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is:

A. For my use in treating you.
B. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
C. For my use in defending myself in legal proceedings instituted by you.
D. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
E. Required by law (the use or disclosure is limited to the requirements of such law).

F. Required by a coroner who is performing duties authorized by law.
G. Required to help avert a serious threat to the health and safety of others (including myself).
PLEASE NOTE: As a psychotherapist, I will not use or disclose your PHI for marketing purposes, nor will I sell your PHI to another entity.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION: Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

A. When disclosure is required by State/Federal law, and when the use or disclosure complies with and is limited to the relevant requirements of such law.
B. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
C. For health oversight activities, including audits and investigations.
D. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an authorization from you before doing so.
E. For law enforcement purposes, including reporting crimes occurring on my premises.
F. To coroners or medical examiners, when such individuals are performing duties authorized by law.
G. For workers' compensation purposes. Although my preference is to obtain an authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

V. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

A. *The Right to Request Limits on Uses and Disclosures of Your PHI*. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would negatively affect your physical, mental, or emotional health.
B. *The Right to Choose How I Send PHI to You.* You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
C. *The Right to See and Get Copies of Your PHI*. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a summary of your PHI within 30 days of receiving your written request. A fee of $75.00 may be charged for the summary.
D. *The Right to Get a List of the Disclosures I Have Made*. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an authorization. I will respond to your request for an accounting of disclosures within 30 days of receiving it. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge unless you make more than one request in the same year. A second request may result in a charge of $75.00; other requests made in the same year may result in a charge of $100.
E. *The Right to Correct or Update Your PHI.* If you believe that there is a mistake in your PHI, or that a piece of important information is missing from it, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 30 days of receiving your request. PLEASE NOTE: In regard to your PHI, I cannot legally change any documentation given to me by another provider. I can only document my personal findings.
F. *The Right to Get a Paper or Electronic Copy of this Notice*. You have the right get a paper copy and/or email copy of this notice.

VI. YOUR ACKNOWLEDGEMENT OF YOUR RECEIPT OF THIS PRIVACY NOTICE:

I AGREE THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signed:_____

Dated:_____

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Informed Consent for Psychotherapy

General Information: The therapeutic relationship is unique in that it is a highly personal and, at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me should you have questions or concerns. Once you have read this document in its entirety, please indicate that you have reviewed the enclosed information and that you agree to it by filling in the checkbox located on the last page.

Therapist's Credentials: One of the purposes of this Informed Consent is to ensure that you have been provided with my credentials. The State of Texas requires that all counselors complete at least 300 hours of close supervision in a Practicum position, complete a 48 semester hour Master level degree in counseling, pass a State licensing exam, and complete 18 months/3000 hours of a supervised internship before a counselor can be licensed as a Licensed Professional Counselor (LPC). I completed all State mandates, and I also fulfilled the extra requirements set forth by my Master program at Capella University, which included an additional 300 Practicum hours, an additional 12 semester hours of specialized course hours, and two intensive Residencies. Please also note that I have met all the requirements of my internship and am fully licensed as a LPC. Therefore, when you sign this document, you are consenting to working with me as a fully Licensed Professional Counselor.

Please note: Most of my CEU elective hours were chosen and completed to strengthen my knowledge and skills in the treatment of trauma and crisis related issues. Such CEUs include training in EMDR and CPT.

The Therapeutic Process: With that being said, you have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in the therapeutic process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior(s) or circumstance(s) will change. I can promise to support you and do my very best to understand you, while I also work to identify repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality: The session content and all relevant materials to the client's treatment will be held as confidential unless the client requests in writing to have all or portions of such content released to a specifically named person(s). Limitations of such client-held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm;
2. If a client threatens grave bodily harm or death to another person;
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years;
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses;
5. Suspected neglect of the parties named in items #3 and # 4;
6. If a court of law issues a legitimate subpoena for information stated on the subpoena;
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. For more details concerning your privacy, please see our document entitled "Notice of Privacy Practices."

PLEASE NOTE: If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize it in any way. However, if you acknowledge me first, I will be more than happy to speak with you; however, please understand I do not feel it is appropriate to engage in any lengthy discussions in public or outside of the therapy office as I cannot guarantee HIPAA compliance.

Thank you for your understanding!

Kimberly Thomas, LPC

I AGREE THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signed:_____ Date:_____

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS: Please remember to cancel or reschedule 24 hours in advance. You may be responsible for the entire fee if cancellation is less than 24 hours. If there are extenuating circumstances such as a family emergency, please let me know, and we will discuss options. Please understand such a fee may be necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

The standard meeting time for psychotherapy is 50 minutes. If you determine you need a greater length of time for your sessions, **please speak to me about your request in advance.**

A $25.00 service charge will be charged for any checks returned for any reason.

NON-EMERGENCY AND EMERGENCY ACCESSIBILITY: If you need to contact me between sessions for a NON-EMERGENCY issue, please leave a message on the business office number (830-431-2290). While I am often not immediately available, I do take your calls seriously and will attempt to return voicemails within 24 hours. Please note that face-to-face sessions are highly preferable to telehealth sessions. However, in the event that you are out of town, sick or need additional support, phone sessions and video chat sessions are available. **IF A TRUE EMERGENCY ARISES, PLEASE CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM.**

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality and the importance of minimizing dual relationships, please understand I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I again cannot guarantee immediate response, and I request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the internet, facsimile machines, and e-mail, is considered telehealth by the State of Texas. Under Texas State law, telehealth is broadly defined as the use of information technology to deliver services and information from one location to another. If you request to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled; (2) All existing confidentiality protections are equally applicable; (3) Dissemination of any of your identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without your consent; (4) There are potential risks, consequences, and benefits of telehealth. Potential benefits include, but are not limited to, improved communication capabilities; convenient access to up-to-date information, consultations, support, improved access to therapy, and reduction of lost work time and travel costs.

Please note that effective therapy is often facilitated by information gathered by the therapist during a person-to-person session(s). Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to, the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical/medical

condition, gait and motor coordination, any noteworthy mannerisms or gestures, basic grooming and hygiene, eye contact (including any changes in the previously listed issues), and facial and body language, etc. Potential consequences thus include pertinent information not being transmitted to the therapist because the client doesn't recognize the significance of such relative information.

MINORS: If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four (4) consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

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Signed:_____ Date:_____

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Client Financial Responsibility & Authorization Form

Thank you for choosing KTHOMAS COUNSELING SERVICES or one of its subsidiaries for your counseling needs. We are committed to providing you with the highest quality services. We ask that you read and sign this form to acknowledge your understanding of our client financial policies.

Client Financial Responsibilities:

- The client (or client's guardian, if a minor) is ultimately responsible for the payment for counseling services whether the client is a cash pay client or insurance pay client.
- We will bill your insurance for you. However, the client is required to provide the most correct and updated information regarding insurance.
- Clients are responsible for payment of copays, coinsurance, deductibles and all treatment not covered by their insurance plan.
- Cash pays, co-pays, co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Clients may incur and are responsible for payment of additional charges if applicable. These charges include: Returned checks- $30.00.

By my signature below, I hereby authorize assignment of financial benefits directly to KTHOMAS COUNSELING SERVICES. I understand that I am financially responsible for charges not covered by this assignment.

Patient Printed Name _____

Guardian Printed Signature (if client is a minor)_____

Patient/Guardian Signature _____

Date _____

By checking the following, I authorize automatic payment through the use of my credit card (*This is optional*):

- Name on Credit Card:_____

  Credit Card Number:_____

  Date of Expiration:_____; CVC_____

I hereby authorize KTHOMAS COUNSELING SERVICES to release medical and other information acquired in the course of my treatment to the necessary insurance companies, third party payers, and/or other healthcare entities required to participate in my care.

Patient Printed Name _____

Guardian Printed Signature (if client is a minor)_____

Patient/Guardian Signature _____

Date _____