MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CLIENT INFORMATION BROCHURE & INFORMED CONSENT

SERVICES AND COUNSELOR INFORMATION:
Welcome to Memorial Heights Counseling. I appreciate being given the opportunity to partner with you in counseling. Memorial Heights Counseling is a private psychotherapy practice owned and operated by Caroline Sweatt-Eldredge, MA, LPC (your Counselor). The purpose of this brochure is to inform you about the structure and nature of the counseling relationship and therapeutic process, answer common questions many people have when beginning counseling, and obtain your consent for treatment. During our first session, we will go over many of the topics and issues covered in this brochure. Additionally, if you have any questions regarding the information in this brochure, please feel free to contact Memorial Heights Counseling at any time during your treatment.

COUNSELING RELATIONSHIP:
During the time we work together, we will meet at regularly scheduled appointments at the Memorial Heights Counseling office. Generally, we will meet about once a week for a 45 to 50 minute counseling session. However, depending on your needs and the treatment plan that we create together, we may decide to meet more or less frequently or for longer or shorter sessions. If you are in a crisis requiring immediate attention beyond your weekly scheduled appointment, please go to your nearest emergency room or call 911. Most of my clients meet with me on a weekly basis for about six months to a year. After that, we often meet less frequently for a period of a few months to monitor and maintain any gains made from counseling. Then, you and I may decide together that it is time for therapy to come to an end. The process of stopping therapy is called termination, and is a very important part of our work. Stopping therapy should not be done casually or abruptly. You have the right to stop therapy at any time for any reason, but I do ask that you commit to a final termination session once you have made the decision to stop therapy. We will review our goals, the work we have done, and any future work that remains for you.

Although sessions may be very intimate psychologically, this is a professional relationship rather than a social one. I do not provide legal counsel, do not make recommendations to the court, and do not represent families in court. I do not provide psychological assessments. If these services are needed, Memorial Heights Counseling can help connect you to the appropriate resources.

It is important for you to know that therapy is an active and involved experience that requires commitment and effort on both of our parts. I view therapy as a partnership between us. You define the problem areas to be worked on. I use some special knowledge to help you make the changes you want to make. Psychotherapy is not like visiting a medical doctor. It requires your very active involvement. It requires your best efforts to change thoughts, feelings, and behaviors. For example, if I don't ask, I want you to tell me about important experiences, what they mean to you, and what strong feelings are involved. This is one of the ways you are an active partner in therapy.

EFFECTS OF COUNSELING:
As we work together, I will discuss your treatment plan with you and explain any therapeutic interventions to be used. At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your perspectives and decisions. These changes may affect your significant relationships, job, and/or understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature

of these changes cannot be predicted. We will work together to achieve your best possible results and will discuss any difficulties that occur as they arise.

CLIENT RIGHTS & RESPONSIBILITIES:
Some clients need only a few counseling sessions to achieve their goals while others may require more long-term services. You have the control and may end the counseling relationship at any time, although I do ask you to commit to participating in a final session in order to officially terminate the counseling relationship. You also have the right to discuss or refuse modification of any counseling techniques. I ask that you agree to come to counseling free from the influences of drugs including alcohol, that you silence your cell phone during our sessions, and that you refrain from any abusive language. If you fail to make contact with me for more than two weeks after your most recent session without scheduling another time to meet, I will close your file and no longer be considered your treatment provider of record. You may need to complete additional paperwork in order to reopen your file. Abuse of these important guidelines will affect therapy and may lead to the need to discontinue services or end the session with the expectation of full payment.

You are responsible for making appropriate payment for services at the time they are rendered unless I have approved an alternative pay schedule.

In addition to these rights and responsibilities, my Notice of Privacy Practices form contains your rights regarding privacy and security of information in accordance with HIPAA. This notice has been included in your intake paperwork packet and is also available to download from my practice's website.

PAYMENT AND FEES FOR SERVICES:
Payment is due upon services rendered unless you make other arrangements that are approved by me. I accept cash, checks, and credit cards for payment. I do not accept insurance; however, upon request I will provide you with the required paperwork for you to be able to file for out of network benefits with your insurance provider.

My regular fees for service are as follows:

- Individual Psychotherapy, 30 minutes: $90
- Individual Psychotherapy, 45 minutes: $135
- Individual Psychotherapy, 60 minutes: $180
- Individual Psychotherapy, 90 minutes: $250
- Family/Couples Counseling, 30 minutes: $100
- Family/Couples Counseling, 45 minutes: $150
- Family/Couples Counseling, 60 minutes: $200
- Family/Couples Counseling, 90 minutes: $275
- Group Psychotherapy, 90 minutes: $50/person
- Telephone Consultations >15 minutes: $40/15 minutes

Missed Appointments: It is important that you provide at least 24 hours notice if you need to cancel a previously scheduled appointment. If you do not provide notice of cancellation within 24 hours of your appointment, you will be charged the full fee for your missed session except for the most serious reasons. As we begin counseling together, I request that you keep a current credit card on file in case I am not able to reach you after a missed session. You may decide to use this card as your regular method of payment,

or you may decide to only use this card in the case of a missed appointment when I am not able to reach you.

Telephone consultations: Between sessions, you may find it helpful to check in about certain issues or events that have occurred in your life. Because our in-person sessions are the most powerful and effective agent of change in the therapeutic process, I do ask that for the most part we reserve our clinical conversations for our scheduled appointments. However, if you find that there are some things you need to consult with me about between sessions, I am available via telephone. The first 15 minutes of our phone call are at no cost to you. After the first 15 minutes, you will be charged $40 per 15 minute interval of consultation. Phone calls regarding scheduling, billing, or other non-clinical topics are included in your usual session fee and will not accrue additional charges.

Extended sessions: Sometimes it may be better to go on with a session rather than stop or postpone work on a particular issue. When this extension is more than ten minutes, I will discuss it with you and obtain your permission to continue. Sessions that are extended beyond ten minutes will be charged on a prorated basis.

APPOINTMENTS & CANCELLATIONS:
You are important to me and I will do my best to accommodate your needs in scheduling counseling appointments. Success in counseling is increased with consistent and regular sessions. I ask that you make your counseling appointment a priority and make every effort to attend weekly or at the recommendation of your treatment plan. If you need to cancel or reschedule your appointment, please give me at least 24 hours notice. I am often able to accommodate. If you do not provide 24 hours notice or do not attend your scheduled appointment, you will be charged the full fee of your session.

I ask that you make every effort to arrive at session on time so that we may use all of the time we have toward your treatment goals. If you are going to be late, please notify me as soon as possible as I may be able to make accommodations. However, if you are late and have not notified me, our session will end on time. If I am running late and cause us to get a late start to our session, you will receive your full amount of session time. If you are 20 minutes late and have not notified me, I will consider your session time cancelled.

Finally, if you intend to discontinue services at any time, I ask that you inform me as soon as possible at (713) 701.9794. I will request a final termination session before services are discontinued.

RECORD KEEPING AND CONFIDENTIALITY:
Discussions between a licensed professional counselor and client are confidential. I follow all ethical standards prescribed by state and federal law, as well as the American Counseling Association. I am required by practice guidelines and standards of care to keep records of your counseling**.** However, no information will be released without your written consent unless mandated by law or as otherwise stipulated in the Memorial Heights Counseling Notice of Privacy Practices provided to you. While most of our work is confidential, the following limitations and exceptions do exist:

a) Disclosure by Client (or Counselor suspicion) of abuse, neglect, or exploitation of a child, elderly, or disabled person must be reported to proper authorities;

b) Disclosure by Client of sexual contact with another mental health professional must be reported to proper authorities;
c) If the Client makes a statement of a plan that endangers self or another person, the Mental Health Mental Retardation Crisis Hotline, sheriff's department, or local police will be notified unless a pre-existing emergency contact person has been established with a Release of Information on file and is available and appropriate given the situation;
d) Counselor is ordered by a court to disclose information;
e) Client directs Counselor to release his/her records in writing for a certain time period;
f) Counselor is otherwise required by law to disclose information.

Additionally, I may use case information for purposes of supervision, professional development, and research. To preserve confidentiality in such cases, I will remove all of your identifying information. If you want a paper copy of any of your records, you may be charged for the cost of copying any documents from your case file.

Therapist Coverage: When I am away from the office for a few days, I have trusted fellow therapists who "cover" for me. This therapist will be available to you in emergencies. Therefore, he or she will need to know about you. Generally, I will tell this therapist only what he or she would need to know for an emergency. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

Texting and Email: In my Notice of Privacy Practices, I further explain how Memorial Heights Counseling works to protect your protected health information. I encourage you to closely review your rights to privacy and security. Although not required, many clients find that text messaging on their phones or email are convenient forms of communication and wish to communicate with me in these ways. Texting and email is not a secure form of communication, but you may release me to communicate with you through text or email if you so choose. Because of the limitations of the medium, I request that you not share any clinical information via text message. I prefer that any clinical information be shared in person or over the phone.

Social Media: I do not accept friend or contact requests from current or former clients on any of my personal social networking accounts. 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. I do maintain professional Twitter, Pinterest, and Instagram accounts and have created a Memorial Heights Counseling page on Facebook. You are welcome to "follow" these accounts if you wish. However, I have no expectation that you will do so. In addition, I want you to be aware of the privacy risks that formally "following" these accounts can create. Others may see that you have connected to the Memorial Heights Counseling accounts and assume that you are receiving psychotherapeutic services. My primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow Memorial Heights Counseling.

Note that I will not follow you back on any social media service. I do not follow current or former clients. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working

relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together during the therapy hour.

REFERRALS:
Should you or I believe that a referral is needed to a higher level of care or service that is not provided through Memorial Heights Counseling, I will provide some alternatives including programs and/or people who may be available to be of assistance upon request. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives. In the instance of my unavailability due to incapacity or other reason, your case will be referred to another professional as mentioned in the previous section. If you are in a crisis requiring immediate attention, please go to your nearest emergency room or call 911.

CONTACTING YOUR COUNSELOR:
Because I do outpatient evaluation and therapy, I cannot promise that I will be available at all times. Although I am in the office Monday through Thursday, from 9 A.M. to 6 P.M., I do not take phone calls when I am with a client. You can always leave a message on my voicemail, and I will return your call as soon as I can. Generally, I will return messages within two business days unless I am out of office. As mentioned previously, you may find it convenient to be able to send me text messages or email. You may consent to sending and receiving texts and emails using the Client Information Brochure Consent Form.

STATE COUNSELING LICENSURE:
I am a Licensed Professional Counselor (LPC) (License No: 70928) licensed and trained to practice counseling and psychotherapy in the state of Texas. I am authorized to practice by the Texas State Board of Examiners of Professional Counselors. If you are dissatisfied with your services rendered, please let me know. My office number is (713) 701-9794 and my email is caroline@memorialheightscounseling.com. If you deem it necessary, you may also contact the Board with any questions, comments, or complaints:

The Texas State Board of Examiners for Licensed Professional Counselors
MC 1982
PO Box 141369
Austin, TX 78741-1369
www.dshs.state.tx.us/counselor
(800) 942-5540

I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CLIENT INFORMATION BROCHURE CONSENT FORM

By signing below, you are indicating that you have read and understood the Client Information Brochure, that any questions you have had about this Information Brochure were answered to your satisfaction, and that you have been furnished a copy of the Information Brochure for your personal records. By the Counselor's signature, the Counselor verifies the accuracy of this statement and acknowledges a commitment to conform to its specifications and hereby consents to provide treatment under terms stated in this form.

FOR INDIVIDUALS OVER THE AGE OF 18

I, _____, am voluntarily agreeing to receive counseling services for myself and I understand that I may stop services at any time.

_____ _____
CLIENT SIGNATURE DATE

_____ _____
COUNSELOR SIGNATURE DATE

FOR INDIVIDUALS UNDER THE AGE OF 18

I, _____, affirm that I am the legal guardian (durable power of attorney/managing conservator) of _____. With an understanding of the above requirements, I do grant permission for my child to participate in counseling and release the Counselor from liability.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

ADDITIONAL CONSENTS

Do you consent to communicate via text message? ☐ Y ☐ N If yes, please initial: _____
Do you consent to communicate via email? ☐ Y ☐ N If yes, please initial: _____

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CHILD & ADOLESCENT HISTORY FORM

This form is to be filled out by the parent or legal guardian of the minor client receiving services. Please answer questions as they pertain to the minor client receiving services.

GENERAL INFORMATION

Person Completing Form: _____ Relationship to Minor Client: _____

Name of Minor Receiving Services: _____ Date: _____

Sex: ☐ M ☐ F Birthdate: _____/_____/_____ Age: _____ Ethnicity (Optional): _____

Name(s) of Parent/Legal Guardian: _____

CURRENT TREATMENT CONCERNS & INFORMATION

Why are you seeking treatment for your child at this time? (Check all that apply)

☐ General Mood Concerns:
- ☐ Depression/Sadness
- ☐ Anxiety/Nervousness/Fear
- ☐ Anger/Aggression
- ☐ Coping with Stress
- ☐ Attention/Focus/Hyperactivity Concerns
- ☐ Self Image/Self-Esteem

☐ General Relationship Concerns:
- ☐ Parenting
- ☐ Adoption/Foster
- ☐ Remarriage/Blended Family
- ☐ Social Skills/Friendships
- ☐ Bullying

☐ Life Event Concerns:
- ☐ Grief/Loss
- ☐ Major Life Event/Transition: _____
- ☐ Separation/Divorce
- ☐ Healing from Past Trauma
- ☐ Career Concerns
- ☐ Educational/School Concerns

☐ General Behavioral Concerns:
- ☐ Substance Use/Abuse
- ☐ Eating Concerns
- ☐ Sleeping Concerns
- ☐ Self-Control

☐ Other: _____

What would you describe as the primary concern or area of focus for treatment?: _____

_____

_____

_____

Please describe what particular event or circumstance led you to make an appointment at this time: _____

_____

_____

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

What symptoms are causing concern, distress, or impairment? (Check all that apply):

☐ Change in sleep patterns (please check which change best applies):
- ☐ Sleeping More
- ☐ Sleeping Less
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty waking up
- ☐ Difficulty staying awake

☐ Concentration/ability to focus (please check which best applies):
- ☐ Decreased ability to concentrate
- ☐ Increased or excessive focus/concentration

☐ Change in appetite (please check which best applies):
- ☐ Increased appetite
- ☐ Decreased appetite

☐ Increased anxiety (please describe): _____

_____

☐ Mood swings (please describe): _____

_____

☐ Behavioral concerns or changes (please describe): _____

_____

☐ Experience of victimization (please check which best applies):
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological/Emotional abuse
- ☐ Non-violent crime victim
- ☐ Violent crime victim
- ☐ Dating violence
- ☐ Domestic violence
- ☐ Human trafficking
- ☐ Survivor of homicide/suicide victim

Has your child or your family experienced any recent changes, transitions, or losses? If so, please describe. (This could include moving, changing schools, death of a friend or family member, income or lifestyle changes, etc.):

_____

_____

_____

☐ Have you had concerns about your child's development in any of the following areas? (Check all that apply):
- ☐ Speech/Language
- ☐ Motor Skills
- ☐ Social skills
- ☐ Behavioral
- ☐ Sensory
- ☐ Emotional Regulation
- ☐ Cognitive/Intellectual

What are your expectations of counseling?: _____

_____

_____

How do you hope your child benefits from counseling?: _____

_____

_____

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

Has your child ever had any previous counseling experience?: ☐ Y ☐ N Date(s): _____

What led you to seek treatment at that time?: _____

What was the result of treatment?: _____

Treatment Provider: _____ Contact Info: _____

May I contact the previous treatment provider(s)?: ☐ Y ☐ N Initial for consent: _____

Is your child currently seeing another treatment provider?: ☐ Y ☐ N For what purpose?: _____

Is your child currently under psychiatric care?: ☐ Y ☐ N For what purpose?: _____

Name of Psychiatrist: _____ Contact Info: _____

Date of last appointment: _____ Past or Present Diagnoses: _____

Current Psychiatric Medication: _____

Purpose of Medication: _____Prescribed by: _____

RELATIONSHIPS & GENERAL HISTORY

Please list all family members or important relationships in your child's life:

Name	Age	M/F	Relationship to client	Living with client?
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N

Are you or your minor child currently involved in any legal cases?: ☐ Y ☐ N If yes, please explain: _____

_____

Is there a current custody case involving your child?: ☐ Y ☐ N

Do you have a custody agreement?: ☐ Y ☐ N

If yes, your counselor will need a copy on file before being able to treat your child.

Does your child or family have a history of CPS involvement?: ☐ Y ☐ N If yes, please describe: _____

_____

Was your child adopted or in a foster care program?: ☐ Y ☐ N

If yes, when did your child join your family?: _____

Where there any complications during pregnancy?: ☐ Y ☐ N If yes, please describe: _____

_____

Were drugs or alcohol consumed during pregnancy?: ☐ Y ☐ N

Was your child born premature?: ☐ Y ☐ N

Were there any complications during birth?: ☐ Y ☐ N If yes, please describe: _____

_____

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

Has your child experienced any hospitalizations or surgeries? :☐ Y ☐ N If yes, please describe: _____
_____
Has your child had any health issues?: ☐ Y ☐ N If yes, please describe: _____
_____
Religious Affiliation: _____ Is faith important to you?: ☐ Y ☐ N
Has your child ever experienced what you would describe as a traumatic event?: ☐ Y ☐ N
If so, please explain: _____
_____
_____
Has someone close to your child passed away?: ☐ Y ☐ N Relationship to your child: _____
If so, please explain: _____
_____
Has your child ever been abused (emotionally, verbally, sexually, or physically)?: ☐ Y ☐ N
If so, please explain: _____
_____
If the abuse was physical, sexual, or the result of neglect, was it ever reported?: ☐ Y ☐ N
What would you say are your child's strengths?: _____
_____
_____
Is there anything else you would want the counselor to know as your child begins treatment?: ☐ Y ☐ N
If so, please explain: _____
_____
_____

_____ _____
PARENT/LEGAL GUARDIAN SIGNATURE DATE

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CLIENT CONTACT INFORMATION FORM

PRIMARY CLIENT CONTACT INFORMATION

Name: _____
First Middle Last
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Primary Phone Number: _____
Type (Circle One): Home / Business / Mobile / Other
May we leave a message at this number? ☐ Y ☐ N
May we send text messages to this number? ☐ Y ☐ N
Secondary Phone Number: _____
Type (Circle One): Home / Business / Mobile / Other
May we leave a message at this number? ☐ Y ☐ N
May we send text messages to this number? ☐ Y ☐ N

ADDITIONAL/SECONDARY CLIENT CONTACT INFORMATION

(If applicable. May include spouse, minor child receiving services, non-custodial parent, etc.)

Name: _____
First Middle Last
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Primary Phone Number: _____
Type (Circle One): Home / Business / Mobile / Other
May we leave a message at this number? ☐ Y ☐ N
May we send text messages to this number? ☐ Y ☐ N
Secondary Phone Number: _____
Type (Circle One): Home / Business / Mobile / Other
May we leave a message at this number? ☐ Y ☐ N
May we send text messages to this number? ☐ Y ☐ N

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CREDIT CARD PAYMENT AUTHORIZATION FORM

In order to receive treatment from Memorial Heights Counseling, we require a credit card on file in case of late appointment cancellations or nonattendance as per the cancellation policy detailed in the informed consent. However, we do accept other forms of payment and you may request to only use the credit card on file in case of late cancellation without prior payment arrangements. By signing and completing this form, you authorize Memorial Heights Counseling and Caroline Sweatt-Eldredge, MA, LPC, to make reoccurring charges to your card regarding treatment received unless otherwise specified. In addition, you agree to allow Memorial Heights Counseling to retain your credit card information on file in order to process payments for sessions attended or for sessions scheduled but not attended without prior notification of cancellation within 24 hours of the scheduled session. You have the right to request a change in form of payment by notifying Memorial Heights Counseling before you receive your scheduled treatment and are responsible for keeping your form of payment current and up to date.

Please designate how this form of payment will be utilized:

- ❒ This is my primary form of payment, and I authorize reoccurring charges to this card for any treatment received. I agree to keep my payment information up to date.
- ❒ This is not my primary form of payment, and I only authorize charges to this card in case of late cancellation without appropriate notification. I will make other payment arrangements for any treatment received.

Please complete and sign:
I, _____, authorize Memorial Heights Counseling and Caroline Sweatt-Eldredge, MA, LPC, to charge my credit card account listed below for counseling and psychotherapy services received beginning on the following date: _____.

_____ _____
CLIENT OR CARDHOLDER SIGNATURE DATE

PRIMARY CREDIT CARD INFORMATION

Account Type: ❒ Visa ❒ Mastercard ❒ American Express ❒ Discover

Cardholder Name: _____

Account Number: _____

Expiration Date (MM/YY): _____ **CVV:** _____

Billing Address: _____

City: _____ **State:** _____ **Zip:**_____

Phone Number: _____

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

NOTICE OF PRIVACY PRACTICES

This notice describes how mental health and treatment information about you may be used and disclosed and how you can get access to this information. Caroline Sweatt-Eldredge, MA, LPC, (hereafter referred to as Memorial Heights Counseling) may use or disclose your protected health information (information that could identify you) in certain ways detailed in this notice. If you have any questions about this notice, please contact us at (713) 701.9794.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you, known as protected health information (PHI). Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice.

- For Treatment. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other medical personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- For Payment. If you are receiving any fee-based services, we may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment you received. For example, we may give your health plan information about you so that they will pay for your treatment.
- For Health Care Operations. We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We may also share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. Examples of health care operations include but are not limited to business-related matters such as audits and administrative services, case management, and care coordination.
- Appointment Reminders, Treatment Alternatives, and Health-Related Services. We may use or disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- Research. Under certain circumstances, we may use and disclose PHI for research. Before we disclose PHI for research, the project will go through a special approval process.

DISCLOSURES REQUIRING A SPECIFIC AUTHORIZATION

Memorial Heights Counseling may use or disclose your protected health information for purposes other than those listed in the previous section when your specific authorization is obtained. A *specific* authorization is written permission that permits only a specific disclosure. You have a

right to revoke all such specific authorizations at any time, provided that the revocations are in writing and that these authorizations have not been relied upon for treatment. If you do give us an authorization, you may revoke it at any time by submitting a written revocation by mail to **Caroline Sweatt-Eldredge, 720 N Post Oak Road, Ste. 280, Houston, TX 77024**.

The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of PHI for marketing purposes;
- Disclosures that constitute a sale of your PHI;
- Mental and behavioral health records; and
- Records of drug, alcohol, or substance abuse treatment.

DISCLOSURES NOT REQUIRING A SPECIFIC AUTHORIZATION

Memorial Heights Counseling may use or disclose your protected health information without a specific authorization in the following circumstances:

- As Required by Law: We will disclose PHI when required to do so by international, federal, state, or local law.
- Suspected Abuse of a Child, Elderly, or Disabled Person: If a Memorial Heights Counseling representative has cause to believe that a child, elderly person, or disabled person has been, or may be, abused, neglected, exploited, or sexually abused, that staff member is legally mandated to make a report within 48 hours to the appropriate state or local agency.
- State Licensure Oversight: If a complaint is filed against a licensed Memorial Heights Counseling representative with the state licensing board connected to their professional licensure, they have the authority to subpoena confidential mental health information from Memorial Heights Counseling relevant to that complaint.
- Judicial Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law. For more information regarding the release of confidential information in Lawsuits and Disputes, see Texas Health and Safety Code Section 611.006 and Texas Rules of Evidence 510 (509 for physician-patient privilege).
- Some Law Enforcement Requests: We can use or share health information about you for workers' compensation claims, law enforcement purposes, health oversight agencies authorized by law, and for special government functions such as presidential protective services.
- Serious Threat to Health or Safety: If a Memorial Heights Counseling representative determines that there is a probability of imminent physical injury by you to yourself or others, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- Business Associates: We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy and

security of your information and are not allowed to use or disclose any information other than as specified in our contract.

- Public Health Risks: We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability. We will only make this disclosure if you agree or when required or authorized by law.
- Data Breach Notification Purposes: We may use of disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

YOUR RIGHTS AS A CLIENT:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Memorial Heights Counseling is not required to agree to a restriction you request if it would affect your care.
- Right to Make Choices About What We Share: You have the right to tell me to share information with your family, close friends, or others involved in your care or in a disaster relief situation. If we are not able to communicate your preferred contact person, Memorial Heights Counseling may share your information if we believe it is in your best interest (e.g., if it is needed to lessen a serious and imminent threat to health or safety).
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of your protected health information by alternative means and at alternative locations. For example, you may not want a family member to know that you are receiving services from Memorial Heights Counseling. If necessary, Memorial Heights Counseling could send written communications to an alternative address upon your request.
- Right to Inspect and Copy: You have the right to inspect or obtain a paper or electronic copy (or both) of your protected health information in our mental health records for as long as your protected health information is maintained in the record. Access to such information may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, Memorial Heights Counseling will discuss with you the details of the request and denial process. Some charges or fees may apply for copies of records made on your request.
- Right to Amend: You have the right to request an amendment or correction of your protected health information in the record. Memorial Heights Counseling has a right to deny your request. On your request, Memorial Heights Counseling will discuss with you the detail of the amendment process in writing within 60 days.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of your protected health information for which you have neither provided consent nor authorization for up to six years prior. We will include all disclosures except for those about treatment, payment, and certain other disclosures (such as any you asked us to make). On your request, a Memorial Heights Counseling representative will discuss with you the details of the accounting process. Upon multiple requests for an accounting, charges or fees may apply.

- Right to Power of Attorney: You have the right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Memorial Heights Counseling will make sure the person has this authority and can act for you before we take any action.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice from a Memorial Heights Counseling representative upon request.
- Right to Request Restrictions Concerning Out of Pocket Payments: If you are paying out of pocket (or in other words, request that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service will not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

OUR DUTIES AS A TREATMENT PROVIDER:

- Memorial Heights Counseling will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by letting us know in writing.
- Memorial Heights Counseling is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices.
- Memorial Heights Counseling is required to let you know promptly if a breach occurs that may have compromised the security of your protected health information.
- Memorial Heights Counseling will never share most of your psychotherapy notes or your information for marketing or fundraising purposes without your written consent. Memorial Heights Counseling will never sell your protected health information.
- Memorial Heights Counseling reserves the right to make changes to the privacy policies and practices described in this notice. Unless a Memorial Heights Counseling representative notifies you of such changes, however, Memorial Heights Counseling is required by law to abide by the terms currently in effect.
- If Memorial Heights Counseling revises our policies and procedures, we will provide you with a Revised Notice of Privacy Practices form and post the revised notice on our website.

COMPLAINTS

If you are concerned that Memorial Heights Counseling has violated your privacy rights or you disagree with a decision made about access to your records, you may contact Caroline Sweatt-Eldredge. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201 or calling 1-877-696-6775. Hope for Families will not retaliate against you for filing a complaint.

Effective: August 2016

MEMORIAL HEIGHTS COUNSELING
Caroline Sweatt-Eldredge, MA, LPC

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

I, _____, acknowledge that I have received and reviewed the Notice of Privacy Practices of Caroline Sweatt-Eldredge, MA, LPC (hereafter known as Memorial Heights Counseling). I understand that Memorial Heights Counseling is required to notify me about their privacy practices and to have me consent to such practices. When Memorial Heights Counseling examines, tests, diagnoses, treats, or refers me, I understand that they will be collecting protected health information about me. I understand that the information collected will be used to determine and implement my treatment plan. I understand that my information may be shared with others as detailed in the Notice of Privacy Practices and I provide my consent for Memorial Heights Counseling to use my information for these purposes.

Note: *If you do not sign this form agreeing to our privacy practices, we may not be able to treat you. If you are concerned about your protected health information, you have the right to request in writing that we not use or share some of it for treatment or administrative purposes. However, we are not required to accept these limitations. After you have signed this consent, you have the right to revoke it in writing by contacting Memorial Heights Counseling.*

_____ _____
CLIENT/LEGAL GUARDIAN SIGNATURE DATE

_____ _____
CAROLINE SWEATT-ELDREDGE, MA, LPC DATE RECEIVED