

Lynn Powell, LMHC Counseling
4540 Southside Boulevard Suite 604 Jacksonville, FL 32216
(904) 502-4813

INFORMATION AND INFORMED CONSENT

Services Provided: Lynn Powell Counseling is a private practice, which provides mental health counseling services. Lynn Powell is the sole owner. Please see above header for practice address. Lynn Powell, LMHC can be reached at 904-502-4813 or you may email Lynn@LynnPowellCounseling.com. I provide a variety of psychological services, including but not limited to individual, couples/family, and group counseling, and psychosocial assessments/evaluations. I use an eclectic style of counseling styles including but not limited to Cognitive Behavioral, Rational Emotive Behavioral, Solution Focused, Schema Therapy, Rapid Resolution Therapy, Hypnosis and others. I will jointly determine the goals of therapy for you and we will make recommendations as we deem necessary, which may involve other professionals.

_____ Client Initials

Records and Diagnosis: I am required by law to maintain records. These records include a brief synopsis of the conversation along with any observations or plans for the next time we meet. These records will not be released without your written consent except in situations described under Confidentiality or HIPAA. Also, if you are going to file for insurance reimbursement, we will need to assign a diagnosis.

_____ Client Initials

Time of Sessions: Individual counseling sessions are available in 30 minute and 50 minute time frames. Couples/Family counseling sessions are scheduled for 60 minutes. Group counseling sessions are scheduled for 45 minutes. Diagnostic Interview and Evaluations are scheduled for 60 minutes. Phone counseling is offered in 30-minute blocks of time. Online counseling sessions are scheduled for 50 minutes.

_____ Client Initials

Fees and Payment: Individual session fees are 30 minutes \$60 and 50 minute \$120. Couples/Family session fees are \$140. Group therapy sessions are \$25. Diagnostic Interview and Evaluation/Paperwork is \$100. Initial phone consultations prior to first visit are free. Phone consultations are scheduled in 30-minute blocks of time for \$60. Online counseling sessions are \$120. **Special letter requests are \$50 plus postage if needed.** Records request copies are pages 1-25 at 50 cent per page, pages 26-unknown at 25 cents per page, including postage if needed. Treatment Summaries and/or Discharge Summaries will be provided for \$50.

As a psychotherapist, I do not encourage you to subpoena me for court due to our inability to protect all of the confidential information from our sessions. If you do choose to release information through consent to an attorney and our services are needed in court, the fees will be \$300 per hour to include preparation, travel time and wait time.

Payment is required at the time services are rendered and made by cash, check Visa, MasterCard, American Express, or Discover. If your check is denied, there is a \$35 charge plus the amount of the original check. At that point, it will be required to pay by cash or credit card. If payment is not provided for the services rendered, this may be reported to a collection agency and the therapist may discontinue treatment. In such a situation, referrals to other professionals will be provided.

_____ Client Initials

Managed Care: If you choose to bill your insurance provider for service you will be responsible for any co-payment due at time of service. Please refer to HIPAA and Privacy Notice about coordination of care between provider and insurance company. If you do choose to bill insurance we ask that every client authorize payment of medical benefits directly to Lynn Powell Counseling. If you want to be billed as "out of pocket" and not bill insurance full payment is due at time of service.

_____ Client Initials

Electronic Transmission: Confidentiality cannot be insured when communicating through electronic media. Be advised that email sent via work place is legally accessible by an employer. The following information should not be transmitted via email: HIV status, pending legal claims, emergency inquiries, medication information and any other sensitive information. Email communication is not to be used for emergency information. Please understand that email communication may escalate into a more serious matter necessitating telephone contact or face-to-face appointment. I will be the only one at Lynn Powell Counseling who has access to your email information. I will respond to all emails that are appropriate within 48 hours. All information transmitted through email will be printed and will become a part of your record, which is securely maintained at Lynn Powell Counseling office. Legal and ethical guidelines insist that all pertinent information be included in your chart-therefore, you may not ask that certain records be deleted. If you do not want certain information in your record, please ensure that such information is not included in email communication. You should know that we will not use email to send group mailings, nor will we provide your address to anyone else, unless you specifically request this in writing.

_____ Client Initials

Distance Counseling: Due to the unique nature of distance counseling it is important for each client to understand special considerations. Each client is different therefore the duration of treatment is different. There is an additional Informed Consent for participation in distance counseling that will need to be completed prior to first session.

I, as the client, acknowledge the limitations inherent in ensuring confidentiality of information transmitted through distance counseling and I agree to waive the privilege of confidentiality with respect to any confidential information transmitted through distance counseling that may be assessed by any third party without my authorization and despite the reasonable efforts of Lynn Powell Counseling to arrange a secure online environment. I will complete all required consents for distance counseling prior to first session.

_____ Client Initials

Cancellations: Scheduled appointments must be cancelled or rescheduled 24 hours prior to the scheduled appointment. If you do not give 24 hour notice of appointment time you will be financially responsible and billed a \$35 fee. _____ Initial

Statements: At your request a monthly statement of services will be forwarded to you by mail and may be used to file with your insurance company. You will need to designate address on HIPAA form.

Emergency Situations: If you are having any thoughts of harming yourself or anyone else you will need to immediately dial 911 or go immediately to the nearest Emergency Room. For any after hour issues that may arise please contact me at 904-502-4813.

Coordination of Treatment: It is important to coordinate treatment between other health care providers you may be utilizing.

-I will sign Release of Information for Lynn to contact my Primary Care Provider to discuss care

___ Accept or ___ Deny ___ Initials

-I will sign Release of Information for Lynn to contact my Psychiatrist to discuss care.

___ Accept or ___ Deny ___ Initials

Confidentiality: Confidentiality is a legal protection and assurance of your right to privacy within the limits of Florida state statutes. It is your right that all communication with me be completely private with few exceptions:

-I consider you a danger to yourself or to others

-A court subpoenas your records I must cooperate.

-You are a minor, elderly or disabled and I believe that you are a victim of abuse I must inform CPS.

-You have perpetrated abuse against a minor, elderly, or disabled person.

-You sign a release of information.

-Information released as outlined in the HIPAA Notice of Privacy Practice.

-You file a suit against me.

-You are under the age of 18 and your parent or legal guardian requests information that I consider necessary for them to support your treatment, I will ask your permission to discuss such issues with them.

My signature below indicates that I have read this statement of information regarding treatment with Lynn Powell and consent to all of the above. Further I have received notice of privacy practices on this date.

Client Name (print): _____ Date of Birth: _____

Client Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

(If under 18 years old) Parent Name: _____ Parent Signature: _____ Date: _____