Dr. Erin L. Pannell
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor
1715 W. FM 1626, Suite 103
Manchaca, TX 78652

NAME: _____

CHILD'S NAME: _____

ADDRESS: _____ CITY/ZIP: _____

PHONE: _____ CAN MESSAGES BE LEFT? Y/N

WORK PHONE: _____ CAN MESSAGES BE LEFT? Y/N

CELL PHONE: _____ CAN MESSAGES BE LEFT? Y/N

EMAIL ADDRESS: _____ CAN MESSAGES BE LEFT? Y/N

LIST OF CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

Dr. Erin L. Pannell
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor
1715 W. FM 1626, Suite 103
Manchaca, TX 78652
PH: 512.280.4425 FAX: 512.605.3724

Client's Full Name: _____

Client's Date of Birth (MM/DD/YY): _____

Client's Address/City/Zip Code (as given to insurance company):
_____
_____

Client's Relationship to the insured: _____ Self _____ Spouse _____ Child _____ Other

Client's Social Security #: _____

Client's Driver's License # and State: _____

****
(This is information about who carries the insurance)

Insured's Full Name: _____

Insured's ID Number: _____

Insured's Address/City/Zip (If different from the client's):
_____
_____

Insured's Phone Number (If different from the client's): (____) _____

Insured's Social Security # _____

Insured's Driver's License # _____

Insured's Policy Group or FECA Number: _____

Insured's Date of Birth (MM/DD/YY): _____

Insured's Employer's Name or School Name: _____

Insurance Plan Name or Program Name: _____

Authorization # (must have prior to your first appointment): _____

Number of sessions approved: _____

Client's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services (Erin Pannell, M.Ed., LPC-S, RPT-S)

Signed: _____ Date: _____

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PROFESSIONAL DISCLOSURE STATEMENT

Qualifications:

I am a Licensed Professional Counselor Supervisor, a Registered Play Therapist Supervisor. I provide comprehensive mental health services to adults, children, and adolescents. My master's degree is from Texas State University and is in counseling and guidance. I have a doctorate degree from Argosy University-Sarasota in Counseling Psychology. Post-graduate work has been acquired through Texas State University as well as through continued education seminars and training certified by the American Counseling Association, International Association of Play Therapy, Texas Association of Play Therapy, and Sandplay Therapists of America.

Experience:

I have counseled hundreds of children, adults, and families from varying ethnic, racial, sexual orientation and religious backgrounds during individual, child and adolescent, and family sessions. I have over fifteen years of combined public and private sector experience in working with moderate to severely impaired adults, children, and adolescents. This experience is centered in Adlerian counseling, meaning, "How does the individual use heredity and environment?"

The majority of my work is in helping individuals who have experienced trauma in a variety of forms. I have – and continue to provide – counseling assistance to those people suffering from relationship difficulties, sexual and physical abuse, parenting problems, as well as crisis counseling for those experiencing difficulties brought on by accidents and natural disasters.

Finally, I have assisted several professors at Texas State University in the areas of group dynamics, play therapy, and child and adolescent counseling techniques. I have also assisted graduate students in conducting play therapy and sandtray sessions in the counseling clinic at Texas State University.

Nature of Counseling:

It is my belief that psychotherapy is offered to assist a person in the difficult task of change. Psychotherapy does not do the work; the client must work the therapy in order to achieve successful change.

Named for Alfred Adler, Adlerian counselors believe the family constellation constitutes the primary social environment. I see my role as assisting the individual work through the four primary areas of theory: 1). Establishing and maintaining a trusting relationship between client

and counselor; 2). Uncovering the dynamics of the patient, including lifestyle and goals, and assessing how they affect life movement; 3). Interpretation culminating in insight; 4). Reorientation.

I challenge and assist the client in developing the skill one needs to have a more fruitful and enjoyable life. To do this, I will be asking some personal question about you, your extended family, and personal background and beliefs. With this confidential information, we can explore your areas of concern through talk therapy, role-playing exercises, Sandtray, Play Therapy, and Art therapy techniques. All of which are designed to release one from where they are "stuck" and unable to live as they choose.

Sessions are approximately 45-50 minutes, depending on the nature of the session and the age of the client. Some people need only a few sessions to resolve their difficulties or concerns. Others often need months or even years to achieve their stated goals. As a client, you are in complete control and can end our counseling relationship at any time. I do ask you to participate in a termination session. You have the right to refuse or negotiate modifications of any suggestions that you may feel uncomfortable experiencing. At any time, either you or I may initiate discussion of possible positive or negative effects of entering, not entering, continuing counseling, and/or refusing certain techniques. I adhere to the ethical standards of the LPC board, the International Association of Play Therapy, and the Sandplay Therapists of America.

Our sessions are psychologically intimate and the need to keep the counseling relationship a professional one rather than a social one is necessary. Our contact will be limited to counseling sessions you arrange with me. In case of an emergency, a priority message can be left on my voice mail, and you will be contacted within 24 hours. An emergency number is available to you during the weekend and can be found on the voice mail, or on my card.

In addition, as a consideration to other clients, as well as your child, please make child care arrangements for small children and siblings.

Explanation of Fees:

Session fees are $125.00 per hour. Payment is required when services are rendered. Clients (or guardians of minors) will be responsible for any insurance co-payment, deductibles, or unpaid claims. Any outstanding balance not paid within 30 days will be turned over to a collection agency for recovery and a $145.00 collection fee will be charged to the client's account.

If an account is turned over for collection the client will become liable for the full amount of charges, including costs of collection, taxes and any court costs that may be incurred. Any discounts or adjustments that have been made to the account may be eliminated. No further services will be rendered until all fees have been paid in full.

Court cases are billed at a flat rate of $1500 per day payable 7 days in advance. This includes but is not limited to testimony or being on 'stand-by' for testimony. Any cancellation of my scheduled appearance will require a 72-hour notice or prepayment will not be refunded. Insurance companies will **NOT** cover court appearances.

When a minor is in counseling, parents are required to attend a session every four to six weeks in which information is shared, and future therapeutic treatment is discussed. Please note this is most important for the child's continued growth in the therapeutic process.

A $40 fee will be assessed for all returned checks. In addition, any fee not paid within 30 calendar days of billing may be turned over to a collection agency or attorney for nonpayment unless a payment plan has been arranged.

If a client or a client's representative requests a copy of their counseling file, a flat administration fee of $75.00 is charged each time the client requests a copy of the file. The request must be in writing with the original signature of the client (parent or guardian of a minor child). This office reserves the right to redact any information from a child's file that the counselor believes places the child's safety in jeopardy. Files will be submitted to the client or client's representative within 45 days.

Cancellations:

A 48-hour cancellation notice is required, otherwise a fee of $75 will be charged to your account as this office cannot bill insurance companies for no-show/late cancellations. In addition, the notice allows for other clients on the waiting list to be seen. If the fee is not paid within 4 weeks, no further services will be rendered until the fee is paid in full.

If a client fails to keep 2 consecutive appointments without notification, the counseling relationship will be terminated, and the client's time slot will be given to another client.

Confidentiality:

All communication occurring between therapist and client will be held in the strictest of confidence. However, if the client is using insurance, an office manager may be responsible for handling your file and billing the insurance company. The office manager is trained in ethics and confidentiality, and will not share information with anyone other than the insurance company and/or its representatives. Also, the insurance company may require the client to sign a release of information for the release of certain portions of your record.

Under normal circumstances, no information will be released to any individual or institution without the written consent of the client. There are circumstances preceding this. According to Texas statutes, confidentiality must be breeched if one or more of the following occur: 1) the client is deemed by the therapist a danger to self or someone else, 2) if child abuse/neglect is suspected, 3) if abuse/neglect of another individual within the family home is suspected, 4) if a court orders confidential records to be released, or 5) if the client agrees in writing for the release of one's information. In the event of one of the above situations, the proper steps will be taken including notification of medical and/or law enforcement agencies as needed.

Referrals:

If any time, for any reason, you are not satisfied with my services, please let me know. If I am not able to resolve those concerns, I will provide three referral choices.

Complaints:

If you have a complaint concerning your treatment and/or your therapist, you may report it to the Texas State Board of Examiners of Professional Counselors at 512.834.6658.

Equality:

I understand that I have the right to fair, equitable and comparable treatment at all times. I understand that I have the right to view my file with a 30-day notification period.

By your signature on the following page, you are indicating that you have read, understood, and agree to the Counseling Contract Conditions. Any questions you may have concerning this agreement have been answered to your satisfaction.

PROFESSIONAL DISCOSURE AND COUNSELING CONTRACT SIGNATURE PAGE

I HAVE READ AND UNDERSTAND THE CURRENT OFFICE PROCEDURES AS STATED WITH REGARD TO APPOINTMENTS, FEES, METHODS OF PAYMENT, HISTORY, CONFIDENTIALITY, AND CLIENTS' RIGHTS, AND AGREE TO ABIDE BY THEM. IN ADDITION, I HAVE RECEIVED A COPY OF THE COUNSELING CONTRACT.

_____

Client Date

_____

Client Date

_____

Parent/Legal Guardian Date

_____

Dr. Erin Pannell Date
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor

DR. ERIN L. PANNELL
Licensed Professional Counselor-Supervisor
Registered Play Therapist-Supervisor
1715 W. FM 1626, Suite 103
Manchaca, TX 78652
512.280.4425

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI),* for *treatment*, *payment*, and *health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment*, *Payment*, and *Health Care Operations*"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, social worker, therapist, psychologist, or psychiatrist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility of coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I

am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Abuse by a Therapist:** If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment**,** I will report this to the appropriate State Examining Board.
- **Health Oversight:** If a complaint is filed against me with the appropriate State Board overseeing me – The Texas State Board of Examiners of Psychologists, The Texas Board of Medical Examiners, the Texas State Board of Social Work Examiners, or the Texas State Board of Professional Counselors – they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative 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, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and My Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send information to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you a revised copy at your next visit or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, talk to me about these concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next visit or by mail.

Rev. 4/8/03

DR. ERIN L. PANNELL
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Acknowledgement of Review of Notice of Policies and Practices to Protect the Privacy of Your Health Information

I have received a copy of this office's Notice of Policies and Practices to Protect the Privacy of my Health Information, which explains how my health information will be used and disclosed and I have reviewed it.

_____

Signature of Patient or Personal Representative/Guardian

_____

Print Name of Patient or Personal Representative/Guardian

_____

Description of Personal Representative/Guardian's Authority

_____

Date