Cotton Counseling and Consulting, PLLC

Informed Consent, Notice of Privacy Practices, Therapist-Client Responsibilities

Therapy Appointments

Your appointment time is reserved for you. It is scheduled according to your personal needs and appointment availability.
Standard appointments are 45-55minutes.

Phone/Email Availability

For all non-emergencies, you can call Cotton Counseling and Consulting PLLC at (832) 210-3908 or email *lindsey@cottoncounseling.com*
I will return most contacts within 1-2business days.
If you are experiencing an emergency, immediately call 911 or go directly to the nearest hospital emergency department.

I consent to receive text messages or emails from my therapist and Cotton Counseling and Consulting PLLC on my cell phone or other devices. I understand that text messages and emails sent by Provider may include appointment reminders or changes in previously scheduled appointments, or may provide advice or education. Standard text messaging rates may apply as provided in my wireless plan.

I understand that I may revoke my request for further communications via text or email at any time by notifying my therapist in writing. However, if I continue to communicate with my therapist via text or email, my therapist can assume that my consent remains valid.

I understand the risks associated with e-mail and text messaging, including, without limitation, that e-mails and text messages could be intercepted by unknown third parties; e-mail content can be changed without the knowledge of the sender or receiver; backup copies of e-mail may still exist even after the sender and receiver have deleted the messages; and e-mail can contain harmful viruses and other programs.

Statement Regarding Confidentiality

- I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive.
- I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment.

All information shared is confidential unless a specific release of information is signed by you, with the following exceptions:

- You express your planned intention of harming yourself or your emotional/mental state is observed by me to put you at risk.
- You share that you have in the past and/or present emotionally, physically, or sexually abused a minor or vulnerable adult.
- You are a minor or vulnerable adult and you share that you are currently, or have in the past, been physically or sexually abused, or I determine that you are at significant risk.
- Your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees, or any legal defense is required by this therapist or Cotton Counseling and Consulting PLLC.
- This therapist or Cotton Counseling and Consulting PLLC receives a signed order by a judge to testify in court or to provide records.

Substance Use Disclaimer

I understand that I will be expected to be sober at the time of my therapy session, and that if I arrive under the influence of any substance, the session will not proceed.

Fees and Insurance Information

All copayments, coinsurance, and fees for therapy sessions are due at time of service.
It is the responsibility of the client to have knowledge of their insurance coverage and responsibilities.
If there are any questions regarding claim submission or rejections/denials, please direct these questions to your insurance company.
This therapist agrees to assist (where able) in these matters.

Notice of Privacy Practice Acknowledgement

In order to provide you care, your therapist and Cotton Counseling and Consulting PLLC must collect, create and maintain health information about you, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. Your therapist is required by law to maintain the privacy of this information. This Notice of Privacy Practices describes how your health information may be used and disclosed, and explains certain rights you have regarding this information. Your therapist is required by law to provide you with this Notice, and will comply with the terms as stated.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Right to File Complaints

If you become dissatisfied with services at any time, please let me know. It is my obligation to provide a list of other professionals that may be of more help to you. For any formal complaints to Texas State Board of Social Workers Examiners, you may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information

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TeleHealth Consent

I understand the following with respect to telemental health:

- I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- Telehealth sessions will take place via Doxy.me, a secure HIPAA compliant platform. To do this, you'll need an Internet connection and computer, cellphone (Android or IOS), or tablet with microphone and camera. telehealth
- For telehealth sessions, please find a quiet and well-lit place, and limit distractions of driving, children, cooking, etc. to have the most productive session.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information:

- **Right to Inspect or Get a Copy of Your Medical Record.** You have the right to inspect or request a copy of health information about you that we maintain. Your request should describe the information you want to review and the format in which you wish to review it. We may refuse to allow you to inspect or obtain copies of this information in certain limited cases. We may also deny a request for access to health information under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.
- **Right to Request Changes to Your Medical Record.** You have the right to request changes to any health information we maintain about you if you state a reason why this information is incorrect or incomplete. Your Provider might not agree to make the changes you request. If we do not agree with the requested changes we will notify you in writing and inform you how to have your objection included in our records.
- **Right to an Accounting of Disclosures.** You have the right to receive a list of all disclosures we have made of your health information. The list will not include disclosures made for certain purposes including, without limitation, disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period covered by your request, which cannot exceed six years. The first time you request a list of disclosures in any 12-month period, it will be provided at no cost. If you request additional lists within the 12-month period, we may charge you a nominal fee.
- **Right to Request Restrictions.** You have the right to request restrictions on the ways which we use and disclose your health information for treatment, payment and health care operations, or disclose this information to disaster relief organizations or individuals who are involved in your care. We are required to comply with your request if it relates to a disclosure to your health plan regarding health care items or services for which you have paid the bill in full, though in other instances, we may not agree to the restrictions you request.
- **Right to Request Confidential Communications.** You have the right to ask us to send health information to you in a different way or at a different location. Your request for an alternate form of communication should also specify where and/or how we should contact you.

- **Right to Receive Notification of Breach.** You have the right to receive a notification, in the event that there is a breach of your unsecured health information, which requires notification under the Privacy Rule.
- **Right to Paper Copy of Notice.** You have the right to receive a paper copy of this Notice of Privacy Practices at any time.

To make a request as described in any of the above, please contact your Provider.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES:

- You agree to inform me of the address where you are at the beginning of every session for safety purposes.
- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only.
- Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Emergency Contact Name

Emergency Contact Phone #

I Have Read And Fully Understand The Above Statements.

Client or Guardian

Signature Date