Safe Counsel

Online Counseling Services

Krystal T. Alexander, LMFT
(615) 669-1125

Counseling Policies

I am encouraged to have the opportunity to work with you. This handout is to provide information helpful in making informed decisions concerning these services. Please ask questions at any time.

I am a Licensed Marriage and Family Therapist, LMFT #1284 in the state of Tennessee.

Appointments:
Counseling services are by appointment only. Sessions are 45-50 minutes, and this is known as the "clinical hour". Because the appointment is reserved for you, it is required that you communicate cancellations or rescheduling needs at least 24 hours in advance of your scheduled appointment. **The full rate is charged for missed appointments or cancellations within 24 hours.** Scheduling and cancellations can be communicated by call, text or e-mail.

I have read and understand this policy (please initial): ______________

Fees:
My standard fee for a clinical hour (45-50 min) counseling session is $105.00. I accept cash, check or credit card (Visa, MasterCard, Discover, American Express); a $5 discount is offered for those who pay with cash or check for their appointment. This fee also includes my time on your behalf outside our session, including record keeping and preparation. Any fees I may incur for returned checks when processing your payment will be billed back to you, so please be sure you have the necessary funds available when choosing your method of payment. **I require that a credit or debit card be kept in my files in order to bill for any missed appointments (*****This card will only be charged with your permission OR in the event that you have not showed for an appointment and have not contacted me to settle your payment*****).**

I have read and understand this policy (please initial): ______________

Collections for Non-Payment:
In the event that your account is not settled (due to a Non-Sufficient Payment or failing to show up for an appointment and the credit card on file not being activated/having the funds to cover the cost of the session), settlement of payment will be pursued from an external collection agency. If this happens the external agency will receive only the basic information necessary to contact you for payment.

I have read and understand this policy (please initial): ______________

Messages:
I do not accept phone calls or check e-mail while I am with clients or outside of my regular business hours. During those times you may leave me a voicemail. It is my policy to return calls, texts or e-mails within 24 hours during the work week (Monday-Friday). In the case of an emergency, please call the crisis hotline at 244-7444 or 911.

I have read and understand this policy (please initial): ______________

Use of Email, Phone and Text Messaging:
Electronic communication may only be used for scheduling or questions about appointments. Tone of voice, emotions and other important communication factors are sometimes assumed or misunderstood in electronic communication so it is important to maintain the work in our scheduled session. In the case that a client feels it necessary to send an update/information to me in between sessions, the following shall be adhered to:

1. The client will be billed for the time it takes to read, respond to, print and file all e-mail(s). (Please note, all communication via e-mail or text messaging that goes beyond basic communication regarding scheduling will be printed out and placed in your file and limitations of confidentiality regarding information shared will not apply)

2. If, in the e-mail communication, the client indicates, either outright or by insinuation that they are planning on harming themselves or someone else, the legal mandate of confidentiality shall be applied. The client will be billed for the time it takes to assess the situation, contact the client, develop a safety plan and contact all appropriate emergency contacts, safety and medical personnel in order to ensure the client's safety.

I have read and understand this policy (please initial): ______________

Social Media:

I do not communicate with clients via my personal social media outlets (e.g. I am not friends with clients on Facebook, LinkedIn, etc.) and will not accept friend requests via these mediums. Alexander Therapy has a Facebook page and Twitter account which clients are welcome to follow; regular resources and inspirational features are updated on these avenues of social media regularly.

I have read and understand this policy (please initial): ______________

Counseling:

Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. They may change employment and begin to feel differently about themselves, and may change other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Infrequently, a patient's distress remains or becomes so high that hospitalization or the use of medication must be considered. I am not a physician and do not prescribe medication; however, at times I may encourage you to consider seeking medical attention. In cases where hospitalization and/or medication may be required, this will be discussed in advance with you and, if necessary, with other responsible parties.

I have read and understand this policy (please initial): ______________

Client Rights:

At any time you may question and/or refuse counseling or diagnostic procedures or ask questions about the process and course of the counseling. Clients are given the respect of the highest level of confidentiality. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions require:

1. that I notify relevant others if I judge that a client has any intention or ability to harm either himself/herself or another individual.
2. that I report any incident of suspected child abuse, neglect, or molestation in order to protect the child or children involved.
3. that in legal cases, my records may be subpoenaed by the court. Confidentiality will be respected in all cases, except as noted above. In those additional cases where in my judgement the maintenance of confidentiality is, in fact, destructive to you, I will inform you of my concern, and you will have the final decision as to whether or not I maintain confidentiality.

When needed, you will be asked to sign a "Consent for Release of Confidential Information" form which will allow me to discuss your evaluation and/or treatment with others (e.g. Physicians, previous counselors, etc.). If you wish, you may also limit the time or release by an expiration date, and/or limit what I have permission to discuss by writing these instructions in the release form.

I have read and understand this policy (please initial): ______________

Termination:

Termination of counseling may occur at any time and may be initiated by either the client or the counselor. I request that if a decision to terminate is being made that the final session may be scheduled to explore the reasons for termination. Termination itself can be a constructive and useful process. If any referral is needed or requested, it will be made at that time.

I have read and understand this policy (please initial): ______________

Clients Who Are Dependents:

If you are requesting services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your dependent's counselor, it is important that the client is able to completely trust me. As such, I keep confidential what the dependent says in the same way I keep confidential what any client says. As the parent or guardian, you have the right and responsibility to question and understand the nature of activities and progress with the dependent, and I must use discretion as to what is an

appropriate disclosure. In general, I will not release specific information that the dependent provides to me; however, I feel it is appropriate to discuss your dependent's progress in broader terms and value your participation in their counseling experience.

In the event that the dependent has parents who are divorced or is going through a custody battle, I require that a parenting plan be presented prior to treatment beginning. If the parenting plan requires that both parents must give consent over treatment and decisions for the child, it will be required that both parents sign all opening paperwork.
I have read and understand this policy (please initial): ______________

Insurance: **I do not file insurance claims. I am not paneled by any insurers**. If your insurance provider or another third party will be covering the cost of your counseling, then you need to make arrangements with them to reimburse you directly. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to the insurance company. We are willing to fill out any part of the form that is necessary. (This may include additional fees and does not insure that they will reimburse you.)
I have read and understand this policy (please initial): ______________

Professional Services: I am available for counseling appointments at select times throughout the week (Tues. 9am-7pm and Wed. 9am-7pm). The phone number that you can reach me on is (615) 669-1125. You can also reach me by email at (info@safecounsel.org).

I am not a certified Custody Evaluator or an Expert Witness, as defined by the legal system. As a therapist, I am not permitted to make any judgments on custody. In the case that I would be subpoenaed to court or involved in any legal matter, the client will be charged a fee of $300 an hour (this includes note taking, phone calls, writing case summaries, time to and from court, etc.). **I do not testify unless required by a court order.**

I have read and understand this policy (please initial): ______________

I look forward to our work together and highly encourage your feedback as we collaborate on your specific therapeutic goals. Please sign and date below to confirm that you have read, understand, and agree and have had an opportunity to ask questions regarding the policies outlined above.

***Print Name*____**

***Signature*____ *DATE* ____________________**

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(615) 669-1125

Demographics

Name:____ Date: ____________________

Address: _____________________________ City:_______________State:_______Zip:__________

County: ______________

It is customary practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address

here: ____

Phone: (H) _______________________ (C) ________________ (W) ____________________________

Email: ___________________________ Method of contact: **Phone** or **Email** (circle one)

Age: ________ DOB: ________ Religious Affiliation: ______________________ Employer: __________
_____________________ Occupation: _____________________________

Marital Status: (circle one) **Single** **Married** (years married _______) **Divorced** **Widowed**

Children: Name Age

____ ____________________

____ ____________________

____ ____________________

____ ____________________

____ ____________________

Referred by: ____

Previous Counseling

Previous Counseling? Yes No Who and When? ____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? ____________________________________

Physician ________________________ Current Medications ___________________________

Are you on disability? _ Please describe ____

Are you currently taking medication for a mental or emotional condition? ________________________

Please list conditions and medications: ____

____

Have you ever been hospitalized for a mental or emotional condition? ___________________________

If so, please list where and when: ____

____

Do you currently use any alcohol or drugs? ____ If yes, what is your substance of choice?

____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? ________________

If yes, please describe: ____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own.

Examples: journaling, exercising, workbooks, prayer, support groups -

____

What are some of your hobbies/interests____

Reasons for seeking counseling:

____

____

____

In a few words, what do you think therapy is all about?____

____

How long do you think therapy should last?_______________ How long are you able to commit to therapy?_____________________________

What personal qualities do you think the ideal therapist should possess? ___________________________

____

Emergency contact information:

Name ____

Relationship: _____________________________________ **Phone:** __________________________________

Client Signature: ____ **Date:** ______________________

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Please mark all that apply to you.

☐1. Depressed Mood
☐2. Lost interest in most activities
☐3. Increased appetite
☐4. Decreased appetite
☐5. Weight Gain
☐6. Weight Loss
☐7. Difficulty going to sleep
☐8. Difficulty staying asleep
☐9. Fatigue, loss of energy
☐10. Feelings of worthlessness
☐11. Inappropriate guilt
☐12. Difficulty concentrating
☐13. Preoccupation with death
☐14. Suicidal thoughts
☐15. Excessive or uncontrollable worry
☐16. Restlessness
☐17. Irritable
☐18. Decreased need for sleep
☐19. Increased talking
☐20. Racing thoughts
☐21. Distractible
☐22. Elevated mood
☐23. Engaging in risky, pleasurable activities
☐24. Mood swings
☐25. Feelings of panic
☐26. Pounding heart, chest pains, shaking
☐27. Shortness of breath, dizziness, sweating
☐28. Recurrent undesirable thoughts
☐29. Repetitive behaviors (hand washing, checking) or mental acts (counting etc.)
☐30. Nausea or abdominal stress
☐31. Fear of losing control
☐32. Fear of dying
☐33. Recurrent intrusive memories
☐34. Flashbacks
☐35. Efforts to avoid memories
☐36. Fear of social situations
☐37. Alcohol problems
☐38. Drug use problems
☐39. Compulsive dieting
☐40. Vomiting, use of laxatives
☐41. Marital problems
☐42. Sexual problems
☐43. Impulsive
☐44. Overwhelmed
☐45. Angry
☐47. Easily upset, on edge
☐48. Careless, forgetful, easily distracted, difficulty organizing, loses things

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Sliding Scale Information and Application

The fee for all types of counseling services is $100 per clinical hour (50 min). You may apply for a sliding scale fee if your household gross income is under $76,000 per year. If you qualify, charges per session are as follows:

76K and above - $100
66K – 75K - $85
56K – 65K - $75
46K – 55K - $65
36K to 45K - $55
26K to 35K - $45

In order to apply, please verify your gross household income by submitting a recent pay stub (for you and spouse if applicable) or a copy of your w-2.

Name of person responsible for payment____

Occupation/Employer of person responsible for payment (and spouse if applicable):

____

____

Please provide GROSS annual amounts for the following income categories:

Salary 1 ___________________________
Salary 2 ___________________________
Social Security income ___________________________
Disability income ___________________________

Additional Resources used to cover expenses ___________________________

Total household income ___________________________

I certify the above information is correct. I will notify Krystal T. Alexander, LMFT of any changes in my household income that would affect my use of sliding scale.

____ ____________________

Signature **Date**

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HIPPA Privacy Practices

We are required by law to follow the practices described in this letter. This letter is a summary of our Privacy Practices, but does not replace the full version which has been made available to you. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this mental health provider. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with a number of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure.

Who has access to your personal information?
Medical/Mental health information about you can be used to:
- Plan your treatment and services. This includes releasing information to qualified professionals who work at this facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:
- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What are your rights?
- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- **You must make this request in writing. We may deny your request if:**
  1. We did not create the entry
  2. The information is not part of the file we keep; or
  3. The information is not part of the file that we would let you see; or
  4. We believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years.
- The first request in a 12 month period is free. We may charge you for additional requests.

- To limit how we use or disclose information about you. For example-not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

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Receipt of HIPPA Notification

(Please print and return with additional paperwork)

I, ________________________________, have received a copy of this office's Notice of Privacy Practices and HIPPA.

SIGNATURE: ____

PRINTED NAME: ____

DATE: ____

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Credit Card Authorization Form

Client Name: ____

Name on Credit Card (if different from client): __________________________________

Fee (per session): _______________________________

Method of Payment: _________ Visa _______ MasterCard _______

Card #:

____

Exp. Date: _________________________ CVC Code: ____________________________

Billing address (must match the address the credit card company has on file):
____

____

I authorize Krystal T. Alexander, LMFT to keep my credit card information confidentially filed with my session records to use as payment for each of my sessions unless other form of payment is provided or requested. I understand I must provide cash or check should my credit card be declined.

Signature: ____

Date: ____________________ Phone Number: ____________________

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Receipt of Forms

I, ________________________________ have received a copy of this office’s Notice of Privacy Practices and Policies, and HIPPA.

SIGNATURE:____

PRINTED NAME:____

DATE:____