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Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

This signature page is in reference to the Federal HIPAA (Health Insurance Portability and Accountability) Privacy Regulation requirements. Federal law requires that all clients be offered a copy of the Notice of Privacy Practices. This notice describes in detail how client health information is used and shared with others.

All reasonable efforts will be made to protect the privacy of client health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by email or fax.

By signing below, I acknowledge that I have been offered a copy of the Notices of Privacy Practices.

Printed Name ____ **Date** ___________

Signature ____

Printed Name (Spouse) _____________________________________ **Date** ___________

Signature ____

When a client is a minor, or is unable to give consent, the signature of a parent, guardian or other representative is required.

Signature of Representative _______________________________ **Date** ___________

Print Name ____

Relationship to Client _____________________________________

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Counseling Services Application

Personal Information

First name	Middle initial	Last name	Today's date:
Street address City State Zip		Birthdate:	Cell Phone:
Email Address	Sex: O Male O Female	Employer name:	

List present or previous health problems:

List any medications you are currently taking and their purpose (ex: Wellbutrin for depression):

Spouse or Parent Information if client is under 18

First name	Middle initial	Last name	Marriage date:
Street address City State Zip		Birthdate:	Cell Phone:
Email Address	Sex: O Male O Female	Employer name:	

List present or previous health problems:

List any medications you are currently taking and their purpose:

Children's Information
Instructions: List all children

Name	Age	Lives with you?	Name	Age	Lives with you?

Other Information (PLEASE COMPLETE THIS SECTION)

What do you hope to accomplish by seeking therapy services at this time?

Have you received counseling services in the past? **YES** **NO**

If yes, please share when and for what issues?

Signature **(Client 1)**	**Signature** **(Partner or parent, if client 1 is under 18)**

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Consent to Treatment & Fee Agreement

Licensing

I am a Licensed Marriage and Family Therapist (LMFT) in the state of Texas (license # 201348). My educational background includes a B.S. in Psychology from Brigham Young University and a M.S. in Human Development and Family Science, with a specialization in Marriage and Family Therapy from Oklahoma State University. Advanced training through the International Institute for Trauma and Addiction Professionals (IITAP) has led to certification as both a Certified Sexual Addiction Therapist (CSAT) and Certified Partner Trauma Therapist (CPTT). In addition, I am also qualified to treat clients using Eye Movement Desensitization and Reprocessing (EMDR), Pia Mellody's Post Induction Therapy (PIT) model, and the Neuroaffective Relational Model (NARM).

Fee Agreement

The billable therapy hour is 50 minutes, in order to allow pre-session planning and post-session documentation. The rate for the 50-minute therapy hour is $200 with the increase of $50 for each additional quarter-hour increment. If the session extends past the hour, I will endeavor to solicit permission to extend the session and inform you of the rate adjustment for the session.

Payment is due at the time of service and will be made via Ivy Pay, a HIPAA compliant mobile payment processing platform. Accepted forms of payment include credit cards, debit cards, FSA or HSA. In instances where a third-party, such as an ecclesiastical leader, has taken responsibility for payment, clients must present a letter, signed by the third-party, stating their willingness to pay for services. Your signature below signifies your agreement to the fee arrangements described above, as well as, your consent for me to mail an invoice, as needed, to any third-party payer.

Cancellation Policy

You are responsible for attending your scheduled appointments. If you need to cancel or reschedule, please provide at least 24 hours' notice prior to your appointment time. Appointments cancelled with less than 24 hours' notice will be charged the full session fee, using your payment card on file, except in cases of genuine emergencies. This policy helps ensure consistent availability for all clients and covers the reserved time that cannot be offered to others on short notice.

Confidentiality

Clients have the legal and ethical right to confidentiality. This means the information shared in therapy will be kept within the context of therapy, except where law or ethics mandates otherwise (as noted below). You must sign a consent to release information before information about you can be released to other people or institutions not covered under the mandates of law or ethics.

Legal/Ethical Duty to Warn/Report. In any of the instances below, your right to confidentiality is limited, and clinical information will be disclosed in accordance with the law.

1) Where there is reason to suspect risk of harm to self or others.
2) Where there is reason to suspect that a child/elder/disabled person may be now or has been physically, sexually, or emotionally abused, or physically or emotionally neglected.
3) Where court action requires me to release information that normally would be considered confidential and privileged. (Refer to *Legal and/or Court Involvement Fees* section)

4) Where information that is received from a legal minor(s) is requested by his/her legal guardian.

In order to provide the best services possible, I participate in peer consultation with other licensed therapists, as needed. During such consultations, no identifying information is disclosed. My office staff and other contracted professionals are trained in HIPPA and are under the same confidentiality obligations I am. If you have any questions regarding your rights to confidentiality, please discuss them with me.

Legal and/or Court Involvement Fees. My clinical expertise is in the therapeutic setting, not legal matters, and I strongly discourage involvement in legal proceedings. Should you, your attorney, or any party subpoena me or request my involvement in court-related matters, you agree to pay $350 per hour (double my standard rate) for all time spent, including preparation, travel, waiting, and testimony, *plus* document preparation fees ranging from $50-250. A $2,000 retainer and $2,000 subpoena processing fee are required, with emergency requests under 10 days incurring an additional $500 charge. All subpoenas will be forwarded to my attorney at your expense. Payment is due within 48 hours, and I reserve the right to suspend services for unpaid legal-related fees. You remain financially responsible regardless of which party initiates my involvement, and any testimony will be limited to factual clinical observations only.

"No Secrets" Policy for Couples and Family Therapy. When working with couples or families, I consider the relationship or family system to be my primary client. While individual sessions remain confidential from outside parties, I maintain a "no secrets" policy between participating partners or family members.

Information shared in individual sessions may be disclosed to your partner or family members when I determine it is clinically necessary for effective treatment. I will use my professional judgment to decide when sharing serves the therapeutic goals, and when possible, I will give you the opportunity to make disclosures yourself first. This policy exists because maintaining secrets can undermine the therapeutic process and may be harmful to your relationships.

Grievance

You are in control of your therapeutic journey and may choose to end our therapeutic relationship at any time. If you have concerns about our work together or feel that you have been treated unfairly, I encourage you to discuss them with me directly. I welcome your feedback and am committed to working with you to resolve any issues that may arise.

If you feel your concerns cannot be resolved directly with me, you have the right to file a complaint with the Texas Behavioral Health Executive Council at (512) 305-7700 or online at bhec.texas.gov.

Contacting Me

I am not available for crisis intervention outside of scheduled appointment times. If you have an emergency, please call 9-1-1, go to your nearest hospital emergency room, or text/call the 988 Suicide & Crisis Lifeline for immediate assistance.

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To protect your confidentiality, please limit voicemails and emails to scheduling matters only. Avoid including therapeutic content or sensitive personal information in these communications. For any confidential discussions, please wait until our next session or request a phone call by emailing me at melissa@cluffcounseling.com or leaving a voicemail at 817-756-9725. All correspondence will be returned within normal business hours, unless otherwise indicated.

The responsibility of payment for services rendered is as follows:

CLIENT: $ ________________ *THIRD-PARTY: $* ________________

By signing below, I (we) acknowledge that I (we) have read the *Consent to Treatment & Fee Agreement* and do consent to receive therapy from Melissa Cluff, LMFT, according to the provisions, stipulations, limitations and fee arrangements outlined above.

______________________________ ________________
Signature (Client 1) Date

____
Print name

______________________________ ________________
Signature (Partner or Spouse) Date

____
Print name

______________________________ ________________
Witness Signature Date

If the client is under 18 years of age, please fill out the following information below:

Minor's Date of Birth ______________

______________________________ ______________________________
Signature of Parent/Guardian Signature of Parent/Guardian

______________________________ ______________________________
Printed Name of Parent/Guardian Printed Name of Parent/Guardian

______________________________ ______________________________
Address Address (if different)

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No Surprises Act Letter

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services. As a reminder, the rate for the 50-minute therapy hour is $175, with an increase of $45 for each additional quarter-hour increment, after 60 minutes. Late cancellations and no-shows will be charged the full session fee. It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in therapy. A complete fee schedule, for the services typically offered by Cluff Counseling PLLC, is available to you. We will continue to collaborate, with you and the other treatment professionals on your team, as applicable, on a regular basis to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this to begin/resume treatment. Please sign and date before your next appointment and return. We encourage you to save a copy or picture for yourself. If you have any questions, please don't hesitate to ask. For more information, or questions, about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 800-252-8154.

Thank you very much,

Melissa Cluff, MS, LMFT, CSAT
License #201348

______________________________ _______________
Signature Date

______________________________ _______________
Signature (Partner/Spouse/Parent/etc)
Date

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Consent to Release Information

I ____ *(PRINT your full name)* authorize Melissa Cluff, M.S., LMFT to disclose/release clinical information received during the course of therapy with the following:

Institution/Person ____

Contact Person(s) ____
(PRINT contact person(s) full name(s))

Phone Number: ____

Address (if applicable): ____

____

____

Information to be released (please be as specific and limiting as you see fit):

____

____

____

I understand that my records are protected under the Federal Confidentiality Regulations (42CFR, Part 2) and cannot be disclosed without my signed consent unless otherwise provided for in the regulations. When such records of the undersigned are released in accordance with the above-stated provisions, the agency releasing the information and its personnel shall be free from all civil and criminal liability.

____________________________________ _______________
Signature Date

____________________________________ _______________
Signature (Partner or parent if client is under 18) Date

____________________________________ _______________
Therapist Date

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Telehealth Informed Consent

This statement of understanding has been prepared to help explain policies and procedures related to electronic services or virtual visits provided by Cluff Counseling PLLC. As a client receiving psychological services through telehealth methods, you, the client, understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email). There are benefits and limitations to this service. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. You may decline any telehealth services at any time without jeopardizing your access to future care, services, and benefits.

3. The same fee rates, including the late cancellation fee, will apply for telehealth, as apply for in-person therapy. Payment for sessions and late cancellations will be made using a HIPAA compliant platform called *Ivy Pay*. You will be able to pay using any credit, debit or HSA/FSA card. Ivy Pay will save your card and your card will be charged on the day of your next session.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the Internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. While specific encryption measures have been taken to protect the information that will be communicated between you and me, the privacy and confidentiality of computer mediated communication cannot be 100% guaranteed.

5. These sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

6. Any family member or other individual that you would like to have present during the virtual visit must also sign this document. To ensure patient safety and privacy, please participate in the virtual visit from a private location. All individuals present for the virtual visit must be within view of the camera so the provider is aware of who is participating.

7. Virtual visits should not be used for emergency mental health needs. In case of an emergency, please follow the General and Telehealth Emergency Plan that you have completed with your therapist.

8. It is your responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

9. The laws and professional standards that apply to in-person psychological services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

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I have read and understand the information provided above. I have discussed it with my therapist. All of my questions have been answered to my satisfaction. I hereby request and consent to telehealth services as a part of my treatment. I understand that this agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. I agree to abide by the terms of this agreement.

______________________________	______________________
Client 1	Date
______________________________	______________________
Client 2	Date
______________________________	______________________
Therapist	Date