Brittany Bridges, MA, LPC
Kairos Counseling, PLLC
8105 Rasor Boulevard, Ste 297 Plano, TX 75024
Ph: (214) 530-5990

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT BRITTANY BRIDGES, LPC, AT THE PHONE NUMBER INDICATED ABOVE.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with Brittany Bridges, LPC. Specifically, "Protected Health Information" (PHI) is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you. PHI contains data about your past, present, or future health or condition, and the provision of health care services to you. By law, I, Brittany Bridges, LPC, am required to follow specific rules on maintaining the confidentiality of your PHI, how I use your information, and how your information is disclosed or shared with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how I will follow those rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage health care operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions you may have.

You have the right to receive, and I am required to provide you with, a copy of this Notice.
I am required to follow the terms of this notice. I reserve the right to change the terms of this notice at any time. If needed, new versions of this notice will be effective for all PHI that I maintain at that time. Upon your request, I will provide you with a revised Notice of Privacy Practices. You may either call my office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure.
This means you have the right to authorize or deny any other use or disclosure of PHI not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or my office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative.
This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of PHI.

You have the right to inspect and copy your PHI.
This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. To access your medical information, you must submit a written request to Brittany Bridges, LPC, detailing what information you want access to, whether you want to inspect it or get a copy of it. Please be advised that written requests for copies of PHI will be subject to a $25 charge, paid in advance, to cover copy and preparation expenses. I may deny your request under limited circumstances.

You have the right to request a restriction of your PHI.

This means you may submit a request, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases I may deny your request for a restriction. Please note that you do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

You may have the right to have us amend your PHI.
This means you may request an amendment of your PHI for as long as I maintain this information. In certain cases, I may deny your request for an amendment.

How I May Use or Disclose PHI
Following are examples of use and disclosures of your PHI that I am permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by my office.

For Treatment. I may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, I will disclose PHI to other physicians who may be involved in your care and treatment. I may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

For Payment. Your PHI will be used, as needed, to obtain payment for health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you.

For Healthcare Operations. I may use or disclose, as needed, your PHI in order to facilitate the efficient and correct operation of my practice. This includes, but is not limited to, business planning and development, quality assessment and improvement medical review, legal services, and auditing functions to insure that I am in compliance with applicable laws.

Other Permitted and Required Uses and Disclosures
I may also use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI.

To Others Involved in Your Healthcare.
Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment. I may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

As Required by Law.
I may use or disclose your PHI to the extent that the law requires the use or disclosure.

For Health Oversight.

I may PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect and Serious Threats to Safety.
I may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. I may also use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, I will only make disclosures to a person or organization able to help prevent the threat.

For Legal Proceedings.
I may disclose PHI in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures.
Under the law, I must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of the Privacy Rule.

Complaints

If you have complaints about this notice or about my privacy practices, please contact me directly at (214) 530-5990 or you may email me at brittany@kairos-counseling.com.

If you are not satisfied with the manner in which I handle the complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services Office for Civil Rights by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**, calling 1-877-696-6775, or by sending a letter in writing to 200 Independence Avenue, S.W., Washington, D.C. 20201.

I will take no retaliatory action against you for filing a complaint.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Client:

I am required to provide you with a copy of my Notice of Privacy Practices. This notice states how I may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Print Name Here

_____ _____
Signature/Guardian Date

_____ _____
Witness Date

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New Client Information

Name: _____ Date of Birth: _____

Address: _____

Social Security Number: _____ Gender: _____ Marital Status: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address: _____

Please check all that apply, read below, and sign:

I authorize that messages may be left for me or calls may be returned to my: Home phone ____ Cell phone ____

Work phone ___ Other person answering my phone numbers ____

I authorize that I may receive written communication to my: Email ____ Home address ____

I acknowledge that Brittany Bridges, LPC, may use email and cellular phone as a means of communication and cannot absolutely guarantee the security of these forms of communication.

_____ _____
Client or Guardian Signature Date

Employer: _____ Occupation: _____

Student: Yes No School: _____

In case of emergency, please notify: _____ at this number _____

Primary Care Physician: _____ Phone: _____

I give permission for Brittany Bridges, LPC, to contact my emergency contact person and/or Primary Care Physician as is necessary.

_____ _____
Client or Guardian Signature Date

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ _____
Client or Guardian Signature Date

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Financially Responsible Person: Name: _____

Relationship to Client: _____ Address: _____

Phone: _____

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Brittany Bridges, LPC.

_____ _____

Signature of Client or Guardian Date

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PATIENT DATA SHEET

Patient Name _____

DOB: _____

Date: _____

Current Problems:	NONE	MILD	MODERATE	SEVERE
Depressed Mood	1	2	3	4
Hopelessness	1	2	3	4
Suicidal Thoughts	1	2	3	4
Disturbed Sleep	1	2	3	4
Appetite Changes	1	2	3	4
Significant Change in Weight	1	2	3	4
Poor Concentration	1	2	3	4
Mood Swings	1	2	3	4
Elated Mood	1	2	3	4
Obsessive Thoughts	1	2	3	4
Tense/Anxious	1	2	3	4
Fearfulness	1	2	3	4
Compulsive Behavior	1	2	3	4
Hallucinations	1	2	3	4
Memory problems	1	2	3	4
Hostility/Anger	1	2	3	4
Violence/Aggression	1	2	3	4
Drug/Alcohol Problems	1	2	3	4
Confusion	1	2	3	4
Recent Loss/Trauma	1	2	3	4
Change in sex drive	1	2	3	4
Decreased pleasure	1	2	3	4
Bathing, Dressing, Grooming	1	2	3	4
Other	1	2	3	4

History of Sexual or Physical Abuse: Y N

Ongoing Sexual or Physical Abuse: Y N

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Please list CURRENT medications:

	MEDICATION	DOSAGE AND FREQUENCY
1.		
2.		
3.		
4.		

(Please note any additional medications on the back of this form)

Please list any PREVIOUS medications:

	MEDICATION	DOSAGE AND FREQUENCY
1.		
2.		
3.		
4.		

(Please note any additional medications on the back of this form)

MEDICATION ALLERGIES:

Have you ever been in a psychiatric hospital in the past? ❑ Yes ❑o No
If yes, please list the facility and the dates of treatment

Have you ever attempted suicide? ❑ Yes ❑ No
If yes, please describe the nature of the event and the date(s) of occurrence

MEDICAL HISTORY

Who is your primary care physician?
Date of last visit Date of last physical
Have you had any of the following:

❑ Heart Disease	❑ Kidney Disease	❑ Chronic Pain	❑ Asthma	❑Other
❑ Lung Disease	❑ Thyroid Problems	❑ Seizures	❑ Diabetes	
❑ Liver Disease	❑ Hypertension	❑ Arthritis	❑ Cancer	

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Please list details of any of the above you have checked or any other health problems? _____

_____

_____

List any surgery you have had: _____

_____

_____

WOMEN ONLY

Who is your gynecologist? _____ Date of Last Examination _____

Date of last period _____ Are your periods regular? ❑ Yes ❑ No

List any gynecological problems you have had _____

_____

Method of contraception _____ How many pregnancies have you had? _____

How many children do you have? _____ Are you currently pregnant? ❑ Yes ❑ No

Are you planning to become pregnant in the near future ❑ Yes ❑ No

FAMILY HISTORY (PSYCHIATRIC HISTORY)

(List any blood relative who has had emotional problems, such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, and anxiety problems)

Problem	Relative	Maternal Side	Paternal Side	Hospitalization

List any physical problems that run in your family

Problem	Relative	Maternal Side	Paternal Side	Treatment

List everyone who lives in your home:

_____

_____

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SUBSTANCE USE

I drink alcohol: ____Never ____Less than once/mth ____1-4 times/mth ____2-3 times/wk ____Daily

I usually drink: ____None ____1-2 drinks/sitting ____3-4 drinks/sitting ____5+ drinks/sitting

I become intoxicated: ____Never ____Less than once/mth ____1-4 times/mth ____2-3 times/wk ____Daily

Last Used: _____ How much?: _____

I have had the following problems related to my use of alcohol:

_____ Binges	_____ Hangovers	_____ Physical withdrawal
_____ Arrests	_____ Passing out	_____ Increased tolerance
_____ Assaults	_____ Job problems	_____ Concern about drinking
_____ Seizures	_____ Sleep problems	_____ Interpersonal problems
_____ Blackouts	_____ Medical problems	_____ Inability to stop after one drink

My drinking is: ____ Occasional/Social ____ A problem ____ A dependency ____ An addiction

I want to stop drinking: ____ No ____ Sometimes ____ Very much

I have been involved in the following treatments for drug and/or alcohol:
____ None ____ AA/12 Steps ____ Inpatient Program ____ Outpatient Program ____ Residential Program

In the **PAST 6 MONTHS** I have used:

____ None	____ Marijuana	____ Sedatives	____ Caffeine	(Cups per day: _____)
____ Cocaine	____ Opiates	____ Hallucinogens	____ Tobacco	(# per day: _____)
____ Inhalants	____ Stimulants			

I have misused prescription medications: Y N

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INFORMATION AND CONSENT FOR TREATMENT

Please read the following information carefully. I am happy to discuss any items in further detail, so please let me know if you have any questions or concerns.

CLIENT RIGHTS AND RESPONSIBILITIES: As a counselor, I am dedicated to helping individuals, couples, and families heal, grow, and change. I am pleased that you chose me to be help you with the issues that brought you here. This document is designed to inform you about my background and qualifications as a therapist and to clarify our professional relationship as well as your rights and responsibilities.

QUALIFICATIONS: Brittany Bridges, LPC has a Master of Arts in Counseling from Dallas Baptist University and is a Licensed Professional Counselor in the State of Texas (#63562). I have completed additional training in Eye Movement Desensitization and Reprocessing (EMDR), an evidenced-based treatment modality designed to alleviate the distress associated with traumatic memories.

TREATMENT: The therapeutic relationship is a unique professional relationship that is tailored to an individual's needs. During the first two sessions you and I will develop therapeutic goals and prospective course of treatment, which can be re-evaluated during the course of therapy. Please be aware that therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no guarantee that therapy will yield a positive result. Change will sometimes come easy but more often it will be a slower process and even frustrating one. I am likely to draw on various psychological approaches during therapy in order to get optimal results. I do not prescribe medication.

MINORS: If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

CONTACTING ME: I am often not immediately available by telephone. While I keep office hours between 9 a.m. and 5 p.m. T-F, I will not answer the phone when I am with a client. If I am unavailable, you may leave a non-emergency related voicemail message and I will make every effort to return your call within 24 hours.

EMERGENCIES: In the event of an emergency, contact your physician, your local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations.

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or unavoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment, or can be exploitive in nature. It is important to realize that in some areas multiple relationships are unavoidable. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. I will not accept you as a client if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will discontinue the dual relationship if you find it is or may interfere with the effectiveness of therapy or your well-being.

REFERRALS: If at any point you or I determine that a referral is needed, I will provide you with referrals and/or resources to assist you. You will be responsible for contacting and evaluating these resources.

SOCIAL MEDIA: Please do not send therapist invites to social media (Facebook, LinkedIn, etc.) as it may compromise your confidentiality and privacy.

YOUR RIGHT TO PRIVACY: I will not share information disclosed in counseling without your written consent. However, there are limits to confidentiality that require disclosure of confidential information if the following applies:

- Active or suspected abuse or neglect of a child, elderly or disabled person.
- You are threatening to harm yourself or others. If this occurs I may need to contact relatives, law enforcement or appropriate authorities to safeguard you or the person(s) you are threatening.
- When insurance company or third party payer requests information to pay claims (if applicable).
- There is a license board inquiry.
- If I am subpoenaed to disclose information.
- On occasion professional consultations with other professionals may be needed to provide quality care, if this occurs identifying information will not be revealed.

HEALTH INSURANCE AND CONFIDENTILAITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary will be communicated to the carrier.

ELECTRONIC COMMUNICATION: Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. If you choose to communicate with therapist via non-encrypted email and/or text messages you are accepting the risks to confidentiality associated with this medium and give permission to respond via standard non-encrypted email.

FEES: The fee for a 45-50 minute individual session is $150. Your initial session will be 90 minutes with the fee being $220. Although I do not file insurance claims you may wish to file an out-of-network claim with your insurance company. You will be responsible for payment to me in full, and at the time of service, and upon request I will provide you with the necessary paperwork to file with your insurance company for reimbursement. **You will be billed in full for missed sessions unless you call 214-530-5990, at least 48 hours in advance, to cancel the appointment.** I accept check, cash, and credit cards for payment. There is a $35 fee for checks returned for non-sufficient funds. If payment becomes a problem for you, please discuss with me so we can make appropriate arrangements. If you maintain a past-due balance, you will not be able to schedule another appointment until you pay this balance.

LITIGATION LIMITATION: Therapist is not an expert witness. Due to the confidential nature of counseling and that it involves sensitive information, it is agreed should you be involved in legal proceedings neither you nor your attorney will call me to testify in court, nor will a disclosure of therapy records be requested. If this is something you require, I will gladly provide a referral to a more appropriate provider. If I am subpoenaed to provide testimony or records in a legal matter, you agree to pay $350/hour for preparation, travel, and attendance at legal proceedings. Payment is due 10 days prior to the court date.

COMPLAINTS: My services will be provided in a professional manner consistent with the legal and ethical standards established by the Texas Board of Examiners of Licensed Professional Counselors. You have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, me, or any policies, please bring it to my attention so it can be resolved as quickly as possible. If a complaint is not resolved, the Texas Board of Examiners of Licensed Professional Counselors can be reached at 1-800-942-5540.

By your signature below, you are indicating that you have read and understand all aspects of this statement. A copy of this document will be provided at your request. Signing indicates that you agree to receive treatment from Brittany Bridges, LPC. You may revoke this agreement in writing at any time.

Client/Guardian Name (Printed)	Date
Client/Guardian Name (Signature)	Date
Brittany Bridges, LPC	Date

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional may report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to us by law in order to ensure their safety.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client's Signature (Client's Parent/Guardian if under 18) Date

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FINANCIAL POLICY

FEES: Counseling sessions are 45-50 minutes long and the charge is $150. The charge for the initial visit is $220 and is 90 minutes long. *Payment is due in full at the time of service.*

INSURANCE: Since Brittany Bridges, LPC is an out-of-network provider I do not file insurance claims; however, upon request I will provide you with a superbill that you can use to file with your insurance carrier for reimbursement.

METHODS OF PAYMENT: Brittany Bridges, LPC accepts cash, checks, and all major credit cards. There is a $35 fee for checks returned for non-sufficient funds.

I value your time as much as you value my time. I will be ready to begin our appointments on time as part of my personal commitment to you. If you arrive late for your session, you will be able to complete the rest of your session but due to scheduling conflicts, cannot stay past your normally scheduled time. You will be financially responsible for the entire session.

MISSED APPOINTMENT POLICY

I understand that there are times when things come up and you must cancel or reschedule your appointment. I kindly ask that you give at least forty-eight hours notice of cancellation by calling (214) 530-5990 so that I may offer your appointment slot to another client. No show appointments or appointments cancelled with less than 48 hours notice will be charged at full fee, except in cases that I determine to be an emergency. The charge will be applied to your credit card on file. *Please note that appointments missed due to inclement weather will not be charged.*

I have read and agreed to the above conditions.

_____ _____

Client or Guardian Signature Date

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Credit Card Authorization

Client Name: _____

Card Holder Name: **(as it appears on card)** _____

Cardholder Billing Address: _____

City _____ State_____ Zip Code _____

Card Number: _____

Circle: MASTERCARD VISA AMEX DISC

Expiration Date: _____ 3 Digit Security Code (on back of card): _____

Is this an Health Spending Account (HSA) card? YES NO

I authorize Brittany Bridges, LPC to charge my credit card for missed appointments or for appointments cancelled with less than 48 hours notice, except when determined by Brittany Bridges to be an emergency.

Cardholder Signature: _____ Date:_____