HIGGINS COUNSELING SERVICES

DISCLOSURE FORM

2500 Quantum Lakes Dr,
Suite 203,
Boynton Beach, FL 33426

Office: (561) 853-1374 Cell: (561) 247-3694
Email: higginscounselingservices@gmail.com
Web: higginscounselingservices.com

HIGGINS COUSELING SERVICES DISCLOSURE

Thank you for choosing Higgins Counseling Services (hereby after referred to as HCS) for your counseling services. The following disclosure is designed to give you information about your time in therapy at HCS. The therapist at HCS is committed to the client's rights of information regarding policies including confidentiality, consent, and administrative services. In keeping with this policy, I have listed below the various office policies for your information. Please read through these, ask any questions you may have and sign where directed. Thank you for allowing HCS to serve you.

COUNSELING CONCEPT:

Therapeutic counseling is provided to individual and families (children, teens and adults). The therapist have adapted a holistic approach when treating each client and utilizes an eclectic combination of interventions, which is based on the needs of the clients. Clients also have the option to integrate Biblical principles into their treatment.

FULL NAMES AND CREDENTIALS OF THERAPISTS:

Claudia Higgins, MSW, RCSWI.

The therapist listed above is the sole employee of HCS. Therapist is currently a Registered Clinical Social Work Intern, and is currently under supervision of a LCSW to complete her licensure requirements. Please feel free to discuss with therapist regarding her specific policies, fees, and schedule.

CONTACT INFORMATION

You may call Office (561) 853-1374) or Cell (561) 247-3694 regarding any questions you may have. After hours, leave a voice mail message with your contact information and you will be contacted the next business day. HCS is not a 24-hour counseling center. In an emergency, please call 911 on go to your nearest emergency room. You may also email higginscounselingservices@gmail.com , however this information is subject to the technology disclosure below.

The Florida Department of Health - Medical Quality Assurance has the responsibility of regulating the practice of licensed and unlicensed persons in the field of psychotherapy. The therapist at HCS has been trained in a variety of treatment methods and will determine which approaches and techniques would most benefit you. These results cannot be guaranteed. Your therapist will be able to discuss average length of treatment for conditions that are similar to yours. You have the right to ask and to know about the techniques and approach of your therapist, and you are also entitled to a second opinion. Please ask your therapist if you would like this information. You may also terminate therapy at any time without penalty as participation in therapy is voluntary.

In a professional relationship (such as ours), sexual intimacy between a therapist and client is never appropriate! If such intimacy occurs, it should be immediately reported in writing to the Florida Board of CSW, MFT, MHC4052 Bald Cypress Way, Bin C08, Tallahassee, FL 32399. For concerns or complaints about licensed or unlicensed mental health practitioners contact the Florida Department of Health - Medical Quality Assurance.

CONFIDENTIALITY

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Client Initial

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. A therapist representing HCS and office personnel will not inform others that you are in therapy and the content of sessions will remain confidential. The only time this confidentiality may be broken is if one or more of the following exceptions/conditions apply:

- If you pose physical danger to yourself or others
- If you disclose that you or another person has physically or sexually abused a child, an incompetent or a disabled person, or an elderly person.
- If you disclose that a child, an incompetent or a disabled person, or an elderly person is suffering due to neglect.

If any of the above are disclosed in session, we are mandated by Florida law to report such information to the appropriate State agency.

Additionally, it is important to know and understand that your information may be shared with other professional therapists and administrators for the purposes of case consultation, supervision, billing and other administrative functions. By your signature below you authorize and release your therapist to provide this information to HCS as a whole. Your therapist may be under supervision, which means your information may be disclosed to a supervisor outside HCS. By your signature you authorize your therapist under HCS to release pertinent session information to his or her supervisor. If you have questions, please ask your therapist.

It is possible that you and your therapist may run into each other in a public place. Should this occur, the therapist must protect confidentiality by not acknowledging you unless you first acknowledge your therapist. If you approach your therapist, contact should be brief and no therapy material should be discussed so confidentiality can be maintained.

NO SECRETS POLICY FOR COUPLES AND FAMILY COUNSELING:

I practice a "no secrets" policy when conducting marital/couples/family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. When in couples or family treatment, an individual session may be scheduled to assist in the overall treatment and when mutually agreed upon. Please understand that any information given in individual sessions will not be held in secret in couples or family therapy. I will encourage the person holding the secret to share the secret during the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as I deem appropriate, or necessary, to support the treatment unit's overall progress and goals. If you are seeking couples or family therapy, each member of the treatment unit must read and initial sections as indicated and sign this agreement.

Clients have been advised of confidentiality, the ‘no secrets’ policies:
Client(s) Initials: _____

RISKS AND BENEFITS

It is important for you to know that therapy can be beneficial but there are also some risks. Often when processing difficult emotions, you may feel sad, angry, tired, and experience some emotional and even physical

strain as a result of the intensity of the therapy process. You should let your therapist know how you are feeling and work with your therapist to contain feelings in between sessions.

TECHNOLOGY

By your signature below, you authorize HCS to contact you by phone using the number you provide at intake. If this is not a safe number to leave messages at, please let your counselor know in writing or note this on the intake packet itself. Your therapist may call you using a VOIP (internet based voice over IP phone) or a cell phone both of which may not be completely confidential because of potential technology issues.

Email is not the most confidential mode of communication. If you choose to use email to send information to HCS or to a therapist, you do so knowing that this information is at risk, and that your counselor may respond via email.

Text messaging is a popular form of communication. If you choose to text your therapist, this information is at risk as this is not a confidential mode of communication. At HCS, your therapist may accept text messages. Please clarify how you would like to communicate with your therapist and if you do choose to text, please keep it to a minimum and use it only for scheduling/logistic purposes.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS.

We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

DECEASED PATIENTS

We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

MEDICAL EMERGENCIES

We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Therapist will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

FAMILY INVOLVEMENT IN CARE

We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

LAW ENFORCEMENT

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Client Initial

We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

SPECIALIZED GOVERNMENT FUNCTIONS

We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

PUBLIC HEALTH

If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

PAYMENT

HCS fees are to be assessed and agreed upon by client and therapist based on the established fee schedule. Currently, HCS **DOES NOT** accept any form of insurance. Acceptable payment methods include cash, checks, debit and credit cards. Once you and your therapist agree upon a fee, this will be reported to HCS for billing and record purposes. The agreed upon fee will be applied based on the cancellation policy noted below *.

Please make checks payable to **Higgins Counseling Services**. There is a $30 returned check fee for any check that we are unable to process due to insufficient funds.

All payments are due at the time of service unless prior arrangements have been made.

SESSIONS

Sessions are normally from 50-60 minutes in length though this may vary based on your individual treatment plan with your therapist.

Please arrive promptly for sessions. Sessions will end at the designated time regardless of when it was started. Therapist is only required to wait 15 minutes past the scheduled time for an appointment before a no-show will be billed.

NO DRUGS, ALCOHOL, OR WEAPONS PERMITTED

No weapons, alcohol, or drugs are permitted on the premises at any time. Smoking is not permitted inside the office. Do not come to your appointment intoxicated. You will be asked to reschedule and you will be charged for the appointment as if it were a “No Show” (the hourly rate agreed upon clinician and client)

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Client Initial

CANCELLATIONS

HCS understands that you may need to cancel an appointment. It is helpful for therapist to know if you are unable to make a scheduled appointment, so we ask that you give us at least 24 hours' notice for any change or cancellation.

***Any late cancellation (less than 24 hours' notice), change, or missed appointment will be charged the full agreed upon session rate.**

AGREEMENT

I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will, although revocation is not retroactive**.**

I have been informed of and read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees for services rendered by my therapist.

If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:

CLIENT

SIGNATURE_____DATE_____

SIGNATURE OF SPOUSE IF

FAMILY/MARITAL COUNSELING _____DATE_____

SIGNATURE OF PARENT OR

GUARDIAN IF CLIENT IS A MINOR _____DATE_____

THERAPIST: _____DATE_____

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Client Initial