



Counseling

A Ministry of All Nations Church

Counseling Agreement for Clients of Tamika T. Lord, MA, Resident in Counseling 757-525-3786

**(Professional Disclosure Statement/Client Agreement/Consent for Treatment/HIPAA
Notice, and General Information)**

Please read this document and complete the forms on pages 8,9. Please keep pages 1-8 and bring pages 8 & 9 to your first session.

About Hope and Healing Counseling (HHC)

Counselor Qualifications and Areas of Practice

Tamika T. Lord received professional training in Counseling and Psychotherapy through Regent University; ultimately earning a Masters' Degree in Marriage, Couples and Family Counseling. Ms. Lord is actively engaged in a Counseling/Psychotherapy Residency working towards her License to practice Professional Counseling in the State of Virginia. She is also an active member of several professional organizations. Her practice addresses the needs of individuals, couples, and families. Her practice is extended to persons of all ages.

Ms. Lord has particular interest in Church Based Counseling; Anxiety Disorders; Grief, Loss, and Trauma; Depressive Disorders; Working with Children and Adolescents; Marriage and Family Issues; Domestic Violence; Career Counseling, and diagnosis and treatment of other mental health disorders and problems in living as described in the Diagnostic and Statistical Manual of the American Psychiatric Association.

Theoretical Orientation

My theoretical approach to counseling is Cognitive Behavioral Therapy (CBT). This is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. As we explore the patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, it will enable you to modify your patterns of thinking to improve coping. CBT has been demonstrated to be an effective treatment for a wide variety of disorders such as depression, anxiety, eating disorders, substance abuse, personality disorders, and bipolar disorder and schizophrenia. CBT is also effective in treating physiological problems such as: chronic or acute pain, sleep disorders, and obesity. Although CBT is my primary approach; other modalities of treatment and techniques are used as necessary to serve client's needs.

In working with children, I may also use Child-Centered Play Therapy (CCPT). This form of therapy creates an emotionally supportive therapeutic atmosphere, which provides the child with psychological safety required to learn emotional and behavioral self-regulation. CCPT is based on 8 research validated principles for decreasing a wide range of child problems, for overcoming traumatic experiences, for developing expressive freedom and creativity, and for building self-esteem and more mature, pro-social behaviors.



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What You Can Expect as a Client at HPC

Counselor and Client Responsibilities and Expectations

Counseling /psychotherapy is most effective when it is a collaborative process. Within the first few sessions, we establish goals for your counseling and therapy and will use these goals to guide the course of our work. Part of this plan may include referral to another mental health or medical professional if there is a need for interventions we cannot provide. We will work diligently to provide you with compassionate and effective counseling and psychotherapy that are respectful of your life experiences and individual perspectives.

Your commitment includes consistently coming to your sessions, being fully engaged in the process, completing tasks we've agreed upon, being honest and forthcoming to the best of your ability, completing work both in and outside of our sessions, doing your best to explore your insights, problems, and needs in productive ways, and communicating concerns you may have about the counseling process. Together, we will strive to make each session a "safe place" to share thoughts and feelings, try new behaviors, and plan for the future. As you progress through counseling/psychotherapy, you may find that you experience rapid relief of symptoms, or that your pain intensifies as you work through it. You may feel that you've made good progress, and then later feel that nothing has been resolved. Each of these experiences are normal and even likely as we work together to resolve problems and facilitate your growth. We ask that you commit to working through the difficult moments even as we celebrate those filled with success and hope. Our ultimate goal is that your counseling experience will provide you with an opportunity for growth and healing.

Role of Diagnosis

Your counselor uses the Diagnostic and Statistical Manual (5th Edition) published by the American Psychiatric Association (2013) to assist in coding any diagnosis we may determine to be appropriate to your situation. Diagnosis serves the purpose of providing a framework upon which we can view your situation and plan treatment. However, unless you authorize it, we do not disclose any information about you, (including your diagnoses) to anyone at any time.

Emergencies

In the event that you need emergency services and cannot contact us, please call the Crisis Hotline at 627-LIFE or 911 or go to your nearest emergency room.

If You Have A Complaint

We believe in professional responsibility. If you think you have been treated unethically and cannot resolve this problem with us, we encourage you to contact Ms. Lord's residency supervisor, Ms. Joanne Moore, LPC, NCC, BCETS, CCH at 757-404-3747 and/or the Virginia Board of Health Professions (800-533-1560) to lodge a complaint. As a "Resident in Counseling", in the State of Virginia, I adhere to the ethical guidelines established for counselors by the American Counseling Association (ACA).

Copies of these ethical guidelines can be obtained online at:

<https://www.counseling.org/resources/aca-code-of-ethics.pdf>



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Parking, HHC Office Spaces, and Boundaries

Please park in the designated parking areas on the street. Please inform us ahead of time if additional privacy is necessary so we can work with you to meet your needs.

We strive to create a peaceful and conducive environment for our work. You are welcome to enter the premises and be seated in the waiting area provided. We ask that you remain in the designated area until your counselor comes to get you. Please let us know if anything in the environment becomes distracting or affects your ability to work. We will make every effort to accommodate your needs.

Scheduling, Cancellation, Communication Policies, and General Information

Scheduling, Length of Sessions, Cancellations

We schedule sessions with our mutual agreement. Sessions are 50-60 minutes in length unless otherwise agreed upon. If you are unable to keep an appointment, please cancel or reschedule at least 24 hours in advance to avoid being charged a missed appointment/late cancellation fee.

No Show/ Late Show /Cancellation Policies

Our goal is to manage our time wisely to serve our clients better. When timely (24 hours or more notice) cancellations occur, it is possible to offer open appointment times to clients on the **appointment waiting list**. We sincerely appreciate your cooperation and understanding of the following policy, which is in effect to encourage timely notice of cancellations:

POLICY: Clients are responsible for a \$25 charge for each No Show/No Call event, and when an appointment is cancelled with less than 24 hours prior notice. The client agrees to pay this charge at or before the next appointment. These charges also apply in the event that a client comes to his or her appointment so late that there is not sufficient time remaining to engage in a therapeutic process. (This will not apply in those instances when the Counselor is also running late due to an emergency or other unforeseen circumstance). These charges may be appealed if extenuating circumstances exist that prevent timely notification of cancellation.

Inclement Weather/Community Emergency Closing Policy

In an effort to protect client safety, we close our office whenever Hampton or Newport News Public Schools close due to inclement weather or other community emergencies. If a weather or emergency event falls on a Saturday, we will notify you personally or update the information on our website.

Messages

Messages may be left on our voice mail at any time. Voice mail is checked regularly between 8am and 7pm seven days a week. We will return your calls as soon as possible. Please indicate your preferred method of communication on your **New Client Form or in your message**.

Phone Calls

Your counselor is available for phone consultation **only in the event of an emergency**. An emergency **is a life threatening need or when immediate hospitalization is indicated**. Unfortunately, the demands of our practice prevent the provision of any other form of unscheduled counseling services via telephone. If you need or want to speak to our counselor before your next scheduled session, please call for an



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earlier appointment time. We will strive to set this appointment within as brief a period of time as possible, and your needs will be relayed to the counselor.

Emails and Text Messages

Email and text messages are not useful methods of communication for counseling purposes. Please do not send private or personal information to us via email or text. We cannot guarantee the confidentiality of any communication sent to us in these ways, nor can we guarantee that emails and texts will be received or read. Likewise, we can't respond to questions or counseling needs described in emails or texts (ethical concerns and severe limitations created by security issues, time lapses, and potential technological problems make this problematic). You may elect, at your own discretion, to email requests for appointments and cancellation notices (please understand that cancellations must be **received** by our office at least 24 hours before your appointment time, and that email delivery times can be affected by many factors). Please do not include personal information about your status or case in these emails.

Please, never use email or texting to communicate an emergency or crisis.

Fee and Payment Policies at Hope and Healing Counseling

Fee Schedule

Hope and Healing Counseling ministry is a not-for-profit, faith-based organization and must recover its operating costs to remain viable. Our fees are designed to ensure that we can pay our staff, insurance, and all other overhead costs. A portion of these expenses is defrayed by donations and contributions, but we must rely on fees to cover most of our costs. It is important, therefore, that payment be made at the time services are provided, unless prior arrangements have been made.

- Counseling and Psychotherapy (50-60 minutes) \$50
- Each Additional 1 to 30 Minutes \$25

Document Requests (Letters, Work, School, or FMLA Forms, Recommendations, etc.)

In the event that we cannot complete any needed documentation during your scheduled appointment time, I will be required to do so outside of your regular session. You will be charged \$50 per hour for all documentation completed outside of your sessions. If you need me to complete documentation for you to assist you (letters to the court or to an employer, FMLA paperwork, documents required by your employer, etc.) PLEASE request it at the beginning of your session so that we can attempt to complete the paperwork during your session time.

Inability to Pay at Time of Service

We are a small practice with limited staff and are unable to dedicate resources to billing, client account management, and debt collection. Therefore, payment is required in full at the time services are provided (unless other arrangements have been made in advance). However, we understand that there may be instances when a client is not able to pay at the time of service. Therefore, we have developed a simple means of helping clients receive services without incurring mounting debt or requiring debt collection protocols. Our policy is as follows:



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In the event that you cannot make your payment at the time of your session, we offer you two options:

(1) Be seen at your scheduled appointment time **after you agree to all of the following:** a) Agree to deliver to our office the full payment of the amount due within **7 days** of your appointment date, **OR** (2) Reschedule your appointment (at least 24 hours in advance of your appointment date and time) to a date when you can have your payment available at the time services are provided.

Defaulted Payments

We believe in the fairness and honesty of our clients and expect that we will be paid outstanding balances in timely ways. However, those few clients who default on payments of fees for services rendered are responsible for all legal and administrative fees related to collection fees related to collection on defaulted accounts. Your signature on this document signifies your agreement to this policy.

Payment of Outstanding Balances/Missed Appointment Fees and Scheduling

We are committed to helping people find healing and growth and work hard to facilitate that process. A growing account balance can create significant stress for the client and compromise our work. What appears to be helpful (e.g. allowing a client to pay later) can actually sabotage our progress. Likewise, research repeatedly bears out the fact that clients who don't pay for services don't engage as fully in the process and receive less benefit in the end. Therefore, we do not bill clients for balances, or use payment plans. If you need this kind of accommodation, please let us know. We can refer you to a competent clinician in a subsidized setting where these options are offered.

To prevent the accumulation of outstanding balances, it is our policy that clients must have a "zero" balance (owe no outstanding fees) before they can schedule an appointment. This policy includes payment of fee balances and any Missed Appointment Fees. We do not want fees to become a hardship or hindrance to progress and hope you can understand the need to comply with these policies so our work can be more productive.

If you accrue an outstanding balance or Missed Appointment Fee, please submit your payment via cash at the time you schedule your next appointment.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA Notice)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a Counselor in Residence approved by the State of Virginia, I create and maintain treatment records that contain individually identifiable health information about you. This notice, among other things, concerns the privacy and confidentiality of those records and the information they contain.

Uses and Disclosures of Information without Your Authorization

Federal privacy rules and regulations allow me to use or disclose your personal health information (without your written authorization) to enable me to provide treatment to you, for billing and related business purposes, to conduct health care operations, and to disclose your protected health information to any health care provider to facilitate their treatment activities.



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Notice of privacy practices

This may include consultations or referrals with other licensed health care providers about your condition, the coordination and management of your health care among health care providers or a third party, communications with insurance carriers and billing agents, and oversight organizations that work to ensure that services are provided in a manner that complies with applicable laws, regulations and professional ethics.

I may be required or permitted to disclose your personal health information without your written authorization in other circumstances including, but not limited to the following:

When compelled by a court, board, commission, administrative agency, arbitration panel, or search warrant as long as the request is lawful and follows the guidelines established by law and the regulations of the requesting entity. For the purpose of Reporting Child or Elder Abuse, Neglect or Domestic Violence to appropriate authorities. To report the need for additional services if I believe you have become a danger to your own safety or to the safety of other persons. To contact you to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.

Uses or disclosures of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure.

Other Uses and Disclosures Requiring Your Authorization

In those instances when I am asked for information for purposes outside of the situations described above, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. Any revocation applies to only that information for which an authorization is required, and is not retroactive to any time prior to the date of the revocation.

Client's Rights and Therapist's Duties You Have The Right To:

Request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. We will discuss this issue if this occurs. Request and receive confidential communications of your private health information by alternative means and at alternative locations. Inspect and/or obtain a copy of protected health information and billing records used to make decisions about you for as long as the protected health information is maintained in the record. I may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. Request an amendment of protected health information for as long as the protected health information is maintained in the record. If requested, I will discuss with you the details of the amendment process. Please understand, however, that I am not required to amend the information in the record.

Generally have the right to receive an accounting of any disclosures of your protected health information. On your request, I will discuss with you the details of the accounting process. Obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.



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My Duties:

I am required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of my legal duties and privacy practices with respect to Personal Health Information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you a copy of these revisions at the next appointment.

Complaints:

If you have questions or concerns related to this Notice or its contents, please contact me. We are pleased to be of service to you. If you have a concern about the privacy of your records or any other element of this policy, you may complain to Ms. Lord's residency supervisor, Ms. Joanne Moore, LPC, NCC, BCETS, CCH. Please submit complaints in writing, to residency supervisor: **Joanne Moore**, at the following address: Still Waters Counseling, 2508 Calumet Dr., Virginia Beach, Virginia 23508 at (757) 404-3747.



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Preferred method of contact:

Over the course of therapy, there may be interruptions/emergencies that come up. Some of these might include but are not limited to: medical emergencies, hospitalization, vacations, training, etc. I will make every effort to inform you and make necessary arrangements in advance when possible. Please provide contact numbers where you can be reached should the need arise.

Primary Phone Number: _____

Is it okay to leave a message at this number? *YES* *NO*

Alternate Phone Number: _____

Is it okay to leave a message at this number? *YES* *NO*

Payment Method Agreement

Please carefully read the statements below and initial:

___ I will not be using medical insurance, and will pay for services out of pocket. I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the Hope and Healing Counseling fee policies, and the No Show/Cancellation Policy. I also acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information.**

Acknowledgement of Policies and Signatures

By signing this document, I indicate that I (1) Have reviewed, understand, and agree to comply with the policies on Pages 1, 2, 3, 4, 5, 6, 7, and 8 of this disclosure statement/agreement, (2) Acknowledge receipt of a copy of the Hope and Healing Counseling HIPAA Notice and (3) Consent to treatment for myself or my minor child. My signature also serves as a release to allow Hope and Healing Counseling to communicate relevant information to my insurance company (if applicable).

Signature of Client(s) and Date

Signature of Guarantor/Parent/Guardian and Date



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Credit Card Registration Form (required to receive services)

Please complete the attached form to acknowledge the payment policies described herein and updates your credit card information. Please bring this form to your next appointment.

Client Credit/ Debit Card Registration Form/ Acknowledgment of Payment Policies

This is a small practice with no additional staff. Unfortunately, we are unable to dedicate resources to billing, client account management, and debt collection. Therefore, payment is expected in full at the time services are provided (unless other arrangements have been made in advance).

Each client is required to submit a completed credit card registration form before services can be provided. In the event that you request a telephone based service, or if you have missed an appointment without giving the required 24 hours notice of cancellation, the associated fees will be charged to your card. If you made prior arrangements regarding payment, but payment has not been received by the agreed upon date, your card will be charged for the balance owed.

Charges are processed using Authorize.net credit card processing service. To facilitate credit card processing, Ms. Lord will mark the letter "L" on the signature line on the Authorize.net payment page in lieu of your signature when processing credit/debit card payments. You agree to maintain an up to date, valid card in your file. Updates to your credit card information communicated by the client or client's representative are automatically entered onto your existing credit card sheet. Your original authorization for use of your "on file" card immediately transfers to the new card information. Your signature below authorizes all actions described herein and signifies your agreement with the policies described in this and related documents. Clients agree to maintain a current, up to date, valid card on file at all times.

Your signature on this form and provision of a registered payment method is a requirement at this practice. If you have a hardship related to this policy, please speak with Tamika to supply an alternate method for clearing account balances. This permission can be revoked at any time upon your written request, as long you have a "zero" balance owed or provides an alternate method of payment. Thank you very much for your understanding and cooperation.

Credit Card Information and Permission

Directions: Please complete this form and submit it to Tamika Lord.

Client(s) Name(s): _____

Cardholder's Name as listed on card: _____
Credit/Debit Card #: _____ Expiration: Month _____ Year _____
CVV Code: _____ Your Zip Code: _____ Type of Card: _____
(3-4# code/back of card) (Visa, MasterCard, etc.) Your
Address: _____ Your Phone: _____

Payment Authorization/Acknowledgements:

By my signature below, I certify that I have read, understand, and agree to abide by the payment policies of Hope and Healing Counseling and authorize All Nations Church or it's agent to charge outstanding fees as they occur (in accordance with the payment policies described herein) to the credit or debit card provided by me in this document. I authorize Tamika Lord, MA, Resident in Counseling, to mark the letter "L" in the signature line of Authorize.net payment processing screen in lieu of my signature to facilitate payment of charges. I certify that the information I have provided herein is accurate and complete. Further, I agree to provide a second credit or debit card or other form of payment and give my permission for representative of Hope and Healing Counseling ministry to charge my outstanding fees/balances to that second or subsequent card in the event that the listed card expires or otherwise becomes invalid. I agree to provide new card or payment option information within 5 days of the deactivation or expiration of the form of payment listed on this form.

Client Signature: _____ Date: _____
Client Signature: _____ Date: _____
Guarantor/ Parent / Guardian: _____ Date: _____