Kelly A. Martin, MAMFC, LPC
Kelly A. Martin Counseling, PLLC
Dba: Sonshine Soul-utions Counseling

2220 North Beach Street Haltom City, Texas 76111
www.sonshinesoulutionscounseling.com Phone: (817) 831-4673

Informed Consent

Welcome to Sonshine Soul-utions Counseling. Thank you for choosing to address your mental health needs through my counseling services. I'll do my best to assist you in making this experience meaningful and productive. This document contains important information about professional services and business policies. When you sign this document, it will represent an agreement between us.

Counseling Process:
I, Kelly A. Martin, hold a Masters Degree in Marriage and Family Counseling. I am licensed by the state of Texas as a Licensed Professional Counselor (LPC). I was a peace officer in Texas for 16 years, and hold Mental Health Peace Officer Certification, as well as Critical Incident Stress Management and Hostage/Crisis Negotiation Certification.

I provide a variety of techniques to facilitate emotional healing. Homework assignments are often designed to assist you in processing the previous session and preparing for the next session. The process of counseling is an individual journey which is determined by each client's circumstances and the will to make positive changes. Initially, counseling may result in the client experiencing uncomfortable feelings or thoughts.

Sometimes things get harder before they get better. Even so, I believe meaningful change is possible. These changes may occur within a few sessions or over a more substantial period of time. You, the client, are in control and may end our professional relationship any time you choose.

Office Policies

Please initial after each policy to indicate you have read and understand

Psychotherapy: Sessions are 50 minutes in length. It's important to stick to the maximum of 50 minutes allotted time per session. It is also very important to arrive on time for appointments. Session times start at the scheduled time and not the time you arrive if you are late. There is a clock in the office that will be used to monitor time of session. When there are 10 minutes left, I will begin to summarize, discuss homework, and prepare for the next session with you. _____

Report writing: I do not typically prepare reports beyond your client progress notes. However, if you'd like me to write a report of session notes, summary of sessions and/or reports for doctors, schools, or any other professional other than a court-related issue, there will be a $50 per hour report-preparation fee. _____

Court policies: It is not my intention to become involved in cases that require my testifying in court. However, should this service be needed, it will be billed at a standard rate of $200 per hour (or portion of an hour). This includes any time spent involved in writing reports of session notes, case preparation, research, court-related phone calls, travel time, witness time, waiting and preparing for testimony. _____

Fee/Payment policy: Payment is due in full either by cash, check or credit card at each session. Rates: $100 per 50 minute individual or couples session; $120 per 50 minute family session; $30 per 50 minute group sessions. Sonshine Soul-utions Counseling is a cash-pay practice and does not accept insurance at this time. If this poses a concern for you, please discuss this with me. Discounts may apply for certain dates/times/and circumstances to be determined on a case-by-case basis. Upon signing this form, you will be aware of the fees you're expected to pay. I do accept Crime Victim Compensation cases and will work with clients regarding fees and will interact with CVC on client's behalf. _____

Cancellations: Please cancel appointments 24 hours before your scheduled time to avoid being charged. Fee for late cancellation or no-show is $50. _____

Email and texting: Please be aware that personal contact sent via email or texting is not always a secure means for communicating information and can potentially be compromised. Thus, confidentiality cannot be guaranteed when emailing or texting information. _____

Professional Relationship: Contacts other than chance meetings will be limited to appointments you arrange with me. I cannot attend social gatherings, accept gifts from you, or relate to you in any other way than in the professional context of our counseling sessions. This is for the best interest of you, as a client, and to ensure that healthy boundaries are set between client and counselor. _____

Emergency care: I make every effort to respond to my messages promptly and return calls during normal business hours. Sonshine Soul-utions Counseling is not a 24 hour crisis center and cannot guarantee that a counselor will be availabile for emergencies. However, if you have an emergency crisis or cannot reach me immediately by telephone, you or your family should call 911, or go to the nearest emergency room for attention. _____

Complaints: I take your mental health very seriously. I make every attempt to provide you with high-quality care. However, if you have concerns or complaints regarding your treatment, please bring it to my attention so we may work together to resolve the problem. If there is not a resolution, you may contact the Texas State Board of Examiners of Professional Counselors at 512-458-7111. _____

Privacy rights for clients who are minors: If your child is participating in counseling, please understand that the specific content of sessions will remain confidential. General reports of your child's progress will be made to you and any information regarding danger to your child will be reported to you immediately. _____

Confidentiality

I will treat the information you share with me with great care. It is your legal right that our sessions and my records about you are kept private. That is why I ask you to sign a "release of information/records" form before I can talk about you or send my records about you to anyone else. In general, I will tell no one what you tell me. I will not even reveal that you are receiving treatment from me. In all but a few rare situations, your confidentiality (our privacy) is protected by federal and state laws and by the rules of my profession. Certain exceptions to confidentiality exist and some of those exceptions include:

- If a client makes a threat to harm self or others, and I believe harm will occur, I will release information to prevent harm from coming to anyone;
- If there is any suspected child or elder abuse or knowledge of any type of abuse, I am required to report this to the proper authorities (either CPS or APS);
- In connection to third party billing (Crime Victim Compensation claims);
- In conjunction with legal proceedings, including licensing complaints, and/or subpoenas for information required by court;
- In consultation with other mental health professionals;

Initials _____ Date: _____

I authorize Kelly A. Martin Counseling, PLLC, dba: Sonshine Soul-utions Counseling to release information which in her opinion is reasonably necessary to protect myself or minor child and/or others from risk of death or serious harm. Said information may be released to whoever reasonably necessary to accomplish protection.
Initials _____ Date: _____

I understand that Kelly A. Martin, MAMFC, LPC may become unavailable due to illness, disability, or other unforeseen circumstances. In light of this possibility, Kelly A. Martin Counseling, PLLC has a TRANSFER PLAN in place for client protection. At such time of unavailability, I authorize Kelly A. Martin Counseling, PLLC to release information to a representative who is prepared to provide necessary or emergency coverage.
Initials _____ Date: _____

Occasionally counselors consult with other health/mental health professionals about client cases. During any consultation, every effort is made to avoid revealing a client's identity. All other professionals consulted are legally bound to keep information confidential. These consultations are very commonplace and routine when counselors believe collaboration with other professionals could enhance their client's ultimate outcomes.
Initials _____ Date: _____

The office of Sonshine Soul-utions Counseling *may* be monitored by digitally recorded video/audio surveillance equipment for safety purposes. The recording is remotely located and access is strictly limited - with confidentiality as a high priority. Recordings will *never* be accessed unless there is an emergency need for reporting of criminal activity to police, or unless information is available that may enhance client/counselor safety upon its release to police.
Initials _____ Date: _____

I understand the above listed and explained limits to confidentiality. I also understand that my client records, including both written and verbally communicated information will be handled with utmost care by Kelly A. Martin Counseling, PLLC, dba Sonshine Soul-utions Counseling.

_____ _____
Signature of client (or parent/guardian) Date

Statement of Understanding

I, the client (or his or her parent/guardian), understand I have the right to not sign this form. My signature below indicates that I have read and discussed this agreement. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in these forms, I can talk to Kelly Martin and she will do her best to answer my questions. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with Kelly Martin before ending therapy with her. I understand that no specific promises have been made to me by Kelly Martin regarding results of treatment, the effectiveness of procedures used by this counselor, or the number of sessions necessary for therapy to be effective. I understand that it will take effort and willingness to change in order for therapy to benefit my life in a positive way.

Client Financial Responsibility

I've discussed and agreed upon a fee for my counseling treatment here at Sonshine Soul-utions Counseling with Kelly A. Martin MA, LPC. I understand the fee amount due is: $_____ per session, for approximately _____ sessions. It is possible there may be additional or fewer sessions, depending upon client preferences and overall progress. This will be discussed by both the client and counselor before a final decision is made by the client to terminate treatment.

Please be advised that the financial responsibility for services and that of any treatment and/or education is that of the client or parent/guardian if the client is a minor.

By signing these policies, I, _____:

- Understand and agree to all of the stated practice/office policies as listed above;
- Understand that by initialing I have indicated that I have read and understand each policy stated above;
- Give full consent for myself or my minor child _____ to participate in counseling/psychotherapy until it is determined that treatment is no longer necessary;
- By signing this release, I give permission to Kelly A. Martin Counseling, PLLC, dba Sonshine Soul-utions Counseling to release information regarding myself or any of my minor children who are in treatment with Kelly Martin as outlined in this statement;
- Acknowledge that I have received a copy of the policies and practices to protect the privacy of your health information form (HIPAA);
- Acknowledge that we have discussed office guidelines, office hours, and availability, including methods of communication;

_____ _____

Signature of Client (or Parent/Guardian) Date

Client Copy – Please keep for your records

Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Policy)
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health records contain personal information about you and all aspects of your health. This information about you that may identify you and what relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This notice of privacy practices describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with the notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy at the office, sending you a copy in the mail at your request, or providing one to you at your next appointment.

How we may use and disclose information about you:

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or to other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We may use and disclose PHI so that we can retrieve payment for the treatment and services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for Crime Victim Compensation (CVC) and to process billing with CVC. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for the purpose of collection.

For Health Care Operations We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, and licensing.

Required by Law Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	Law Enforcement	National Security
Judicial and Administrative Proceedings	Deceased Persons	Public Health
Emergencies	Public Safety (Duty to Warn)	