THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLLY.

EFFECTIVE DATE: January 1, 2005

Ashley Kuehne, LPC-S, LCDC recognizes the importance of confidentiality of client communications in the therapeutic and counseling process and agrees to treat information obtained confidentiality in accordance with law and professional standards. I understand that confidentiality is not only and ethical concept but also a legal concept and that certain exceptions to confidentiality exist.

Use and disclosure of protected health information for the purposes of providing services.

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow use to use and disclose your health information for these purposes. I understand that Ashley Kuehne, LPC-S, LCDC may communicate confidential information when permitted or required by law. Some of the exceptions include reporting a child or elder abuse, in response to legal process, in conjunction with legal proceeding including complaints, in connection with billing efforts or in conjunction with treatment efforts for persons operating under her direction.

I also authorize Ashley Kuehne, LPC-S, LCDC to disclose confidential information when required by the code of ethics for professional associations to which she belongs; or in other circumstances where release appears proper as viewed by Ashley Kuehne, LPC-S, LCDC using her best professional judgment. This may include referral sources, consultation, supervision and to provide, mange or coordinate care. I also authorize Ashley Kuehne, LPC-S, LCDC the release of confidential information for the purpose of processing third party payor forms, including verifying insurance coverage, or when obtaining payment for third party payors, including processing claims and collecting fees.

I authorize Ashley Kuehne, LPC-S, LCDC to release such information about me which in her opinion is reasonably necessary to protect others from risk of death or serious harm, including information regarding my sexually transmitted diseases. Said information may be released to whoever is reasonably necessary to accomplish protection. I further understand that it may be beneficial in the course of my therapy to release information to family members or others. I, therefore, specifically authorize the release of confidential information to the following:

1. _____
2. _____
3. _____

I understand that any and all of my confidential records are the property of Ashley Kuehne, LPC-S, LCDC. I understand that Ashley Kuehne, LPC-S, LCDC may be unavailable at times due to illness, emergency, vacation or death. At that time, I authorize Ashley Kuehne, LPC-S, LCDC to release information to her substitute personal representative (Patty Germany, LMFT) at 972-774-9595. The term "information" as used in this release means all information contained in written records and also information known to Ashley Kuehne, LPC-S, LCDC, which may be communicated verbally. By signing this release, I also give Ashley Kuehne, LPC-S, LCDC permission to release information regarding my minor child(ren).

I give consent to inform my Primary Care Physician that Ashley Kuehne, LPC-S, LCDC is treating me.

_____Yes _____No (If Yes, name and phone number_____)

AGREEMENT FOR SERVICES Provider: Ashley Kuehne, LPC-S, LCDC

I give consent to inform my Psychiatrist and/or Psychiatric Nurse Practioner that Ashley Kuehne, LPC-S, LCDC is treating me.

_____Yes _____No (If Yes, name and phone number_____)

Protected health information and technology.

I understand that Ashley Kuehne, LPC-S, LCDC cannot guarantee confidentiality in regards to electronic communication. It is never advised to transmit confidential material to Ashley Kuehne, LPC-S, LCDC via electronic means, including email, text messaging, sykpe and other electronic means. If you choose to communicate electronically, Ashley Kuehne, LPC-S, LCDC is not liable for any unforeseen breach of confidentiality, including illegal "hacked" email accounts, email viruses, theft of electronic devices, sensitive material being made public, and other unforeseen breaches of confidentiality.

The use of texting and emailing needs to be limited to scheduling and basic information exchanges and will not include therapy related information. Ashley Kuehne, LPC-S, LCDC is not a crisis facility available 24 hours a day. If you need immediate assistance and are in crisis please call 911 or visit the nearest hospital. Do not ever communicate crisis related information via electronic means as there is no guarantee in how quickly it will be received. All crisis information (suicidal thoughts or intent, life threatening or immediate medical related information) should be communicated directly to emergency services.

I understand that Ashley Kuehne, LPC-S, LCDC uses a website called TherapyAppointment.com which stores protected health information, including but not limited to appointments, scheduling, billing, case notes, treatment plans, insurance claims, etc. Ashley Kuehne, LPC-S, LCDC is released from all liability of any unforeseen security breaches at TherapyAppointmen.com. I understand that Ashley Kuehne, LPC-S, LCDC has made her best efforts to use a website that is encrypted, HIPAA compliant and secure but cannot guarantee confidentiality with internet safety.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Representative	Relationship to Patient
_____	_____
Date Signed	Witness

HIPPA AGREEMENT Provider: Ashley Kuehne, LPC-S, LCDC

HEALTH INSURANCE PORTABLITY AND ACCOUNTABILITY ACT OF 1996

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF HIPAA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:
The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out his health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

I understand that, and consent to, the following means of communication may be used by the Provider:

- All information entered into www.therapyappointment.com program contact information (including but not limited to home address and mail communication, cell phone and voicemail communication, email and written communication, and web portal messaging communication).

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations. I understand I have a right to inspect and copy my medical billing records, but I will be responsible for any charges incurred in making copies. The provider may deny this request but will be required to offer an explanation for the denial.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this Consent. All requests to revoke consent must be in writing. I understand that my PHI will be kept securely by provider until six years from the last date of contact with provider, and then my PHI will be shredded.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me. I have read and understand the foregoing notice, and all of my questions have been answered to me full satisfaction in a way that I can understand.

Name of Individual (Printed)	Signature of Individual
Signature of Representative	Relationship to Patient
Date Signed	Witness

AGREEMENT FOR SERVICES Provider: Ashley Kuehne, LPC-S, LCDC

I request that ASHLEY KUEHNE, LPC-S, LCDC provide psychotherapy services to me and if applicable, to my minor child(ren).

Ashley Kuehne, LPC-S, LCDC has been either trained or informed in various therapeutic models and approaches and I understand that the following therapeutic techniques may be used: cognitive behavioral therapy (CBT), solution focused therapy, family systems therapy, Eye Movement Desensitization and Reprocessing (EMDR), IMAGO, motivational interviewing, acudetox, dialectical behavior therapy (DBT), post induction therapy (PIT), somatic experiencing, play therapy, art and expressive therapies, and/or clinical hypnosis and I understand that other therapeutic techniques may be implemented during the therapeutic process that may not be listed above. I understand that any therapeutic technique used by the counselor will be in my best interest, and I have the right to decline any therapeutic technique.

Psychotherapy can have benefits and risks and the goals vary based on each individual. Within the first few sessions, Ashley Kuehne, LPC-S, LCDC will work closely with you to determine your specific goals for therapy, whether it be reduction in troubling symptoms, processing and healing from past traumas or learning new coping skills, the options for goals in treatment are many and are tailored specifically to your needs. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However Ashley Kuehne, LPC-S, LCDC cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, Ashley Kuehne, LPC-S, LCDC will anticipate these risks and discuss them with you throughout the course of therapy.

I agree to a fee of $150.00 per 50 minute sessions. All phone calls will be pro-rated to $2.50 per minute. All group sessions (other than couple and/or family therapy) are $50 per group. If I billing a third party payer, I agree to pay the co pay amount at the time the service is rendered. I agree to pay $70.00 for missed appointment unless I provide Ashley Kuehne, LPC-S, LCDC with notice of cancellation 24 hours in advance. I understand that the missed appointments will be noted on the bill, and that third party payers (if applicable) do not pay for missed appointments, and I am responsible to pay for those missed appointments. Requests for records without a court order are at the discretion of Ashley Kuehne, LPC-S, LCDC. I agree to a fee of $0.40 / page for black and white copies of records.

For legal proceedings that require your therapist's response, Ashley Kuehne, LPC-S, LCDC will bill $300 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). The court fee will be billed at the stated amount with a **4-hour minimum** charge. Payment is due and is **non-refundable 48 hours in advance**. Any additional time spent on the day of court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectation of payment. You are responsible for **ANY legal fees** that Ashley Kuehne, LPC-S, LCDC incurs as related to your case or treatment (including, but not limited to, any legal consultation that is sought regarding your case or treatment). Ashley Kuehne, LPC-S, LCDC reserves the right to suspend services if there is an unpaid balance in your account. With regard to litigation, please note that a Licensed Professional Counselor (LPC) is not considered an expert witness in the courts. LPCs are considered a "witness of fact" in the state of Texas. Any testimony given by LPCs in court will be allowed only as a "witness of fact". **Payment will be expected from you, regardless of whose attorney subpoenas my involvement**. Patient records will not be released without written consent, unless court ordered to do so.

Ashley Kuehne, LPC-S, LCDC and any other person who has an office in the same suite are practicing as individuals. The arrangement is an office sharing arrangement only and is not a partnership or similar entity.

I understand that I have the right to complain about the Provider. I agree to contact the Provider first with any complaints and if not satisfied, I have the right to issue a complaint to the U.S. Department of Health and Human Services at 1-800-368-1019 without any fear of retaliation from the Provider. Violations of Licensed Professional Counselors Act may be reported to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, phone 800-942-5540.

I have had an opportunity to read this Agreement and I agree with all of the provisions contained in this agreement. I understand that if I have any reservations, I should not sign this Agreement. Ashley Kuehne, LPC-S, LCDC has offered to answer any questions and I understand the agreement above.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian's Signature if Client is a minor Date

Name on Credit Card	
Credit Card Number	
Expiration Date	
Security Code	
Billing Address and zip code	

As stated in the AGREMENT FOR SERVICES, I agree to the following fees for services:

- $150 for each 50 minute session (individual, family, couple and initial diagnostic interview). Sessions longer 50 minutes will be billed at 10-minute increments charged at $25/10 minutes.
- Phone calls will be billed at 10-minute increments charged at $25/10 minutes.
- $50 for each group psychotherapy session.
- $70.00 for missed appointment unless I provide Ashley Kuehne, LPC-S, LCDC with notice of cancellation 24 hours in advance.
- If billing a third-party payer, I agree to pay the co pay amount at the time the service is rendered.
- $300 per hour for legal proceedings

- $0.40 / page for black and white copies of records.

By signing this form, I authorize Ashley Kuehne, LPC-S, LCDC to keep my credit / debit card on file at www.therapyappointment.com and charge my credit / debit card for all services listed above. If I choose to pay with check, I agree to a $35.00 fee for all returned or cancelled checks.

_____	_____
Client Name	Date of birth
_____	_____
Client Signature	Date

AUTHORIZATION AND ASSIGNMENT FOR INSURANCE Provider: Ashley Kuehne, LPC-S, LCDC

Client Name:_____

To: Ashley Kuehne, LPC-S, LCDC
In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information
You are authorized to release any information you deem appropriate concerning my condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as result of professional services rendered by you, and I hereby release you of any consequences thereof.

Assignment of Cause of Action
In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth below), and authorize you to prosecute said action either in my name or your names as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Provider
To: _____
(Name of insurance company)
In consideration of the services rendered and to be rendered, I authorize and direct payment to the provider named above of any sum I now, or hereafter owe by any insurance company obligated to reimburse me for the charges for his services and to make payment directly to the provider based in whole or in part upon the charges made for services rendered. If my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Ashley Kuehne, LPC-S, LCDC
14114 Dallas Parkway, Suite 245
Dallas, TX 75254

Acknowledgement and Understanding
I understand that if it is determined either:
(a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the provider, or make other provisions for the protection of the interests of the provider;
(b) If a liability claim exists, and my attorney refuses to agree to protect the interests of the provider, or if I have not engaged the services of an attorney; then, payment for services rendered by the above-named provider will be made on a current basis and my bill paid in full as soon as my liability claim is settled, or the passage of three months from my last session, whichever occurs first.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian's Signature if Client is a minor Date

Client Name Date

1. You have the right to be treated fairly and with respect.

2. You have the right to ask questions at any point in the therapeutic process.

3. You have the right to request another therapist and receive competent referrals.

4. All people, including your therapist, have biases and values. You have the right to a therapist who will acknowledge personal values and will not attempt to impose them on you. The job of the therapist is to help you find your own way.

5. You have the right to ask about your therapist's training, theoretical orientation, techniques, and supervised experience.

6. You have the right to ask about your therapist's policy regarding confidentiality. You have the right to grant or deny permission to your therapist to discuss your progress with others.

7. You have the right to know your therapist's policy regarding medication. A medical doctor (M.D. or D.O.) is the only person who can prescribe medication. You have the right to take or not to take medication, to discuss pros and cons of it, and to be involved in the decision. If you disagree with your therapist about whether you should take medication, you have the right to seek another opinion.

8. You have the right to discuss what is happening in your session with other people and to consider and accept or reject this feedback about your progress.

9. You have the right to have a consultation with another therapist. It is usually a good idea to discuss your wish for a consideration with your present therapist, whether or not your therapist agrees. If after such discussion you still wish to have the consultation, it is important for you to trust your own feelings and use your own judgment. The Texas State Board Of Examiners Of Professional Counselors code of ethics prohibits therapists from providing counseling to an individual concurrently receiving counseling treatment intervention from another mental health services provider except with that provider's knowledge. Rule 681.41 (n)

10. You have the right to stop counseling when you want, whether or not your therapist agrees with your decision. It is usually worthwhile to discuss with your therapist your reasons for wanting to stop your sessions. However, the decision is always yours.

11. In the event of an "emergency" you are encouraged to go to the nearest Hospital Emergency Room or to call Green Oaks Hospital at 972-991-9504. If you leave a message, your therapist will call you back as soon as possible.

I understand and have received a copy of my rights as a client seeking therapeutic counseling services.

_____ _____

Client Signature Date

Client Name Date

INFORMED CONSENT TO THE USE OF CLINICAL HYPNOSIS IN TREATMENT

Statement of Choice

Ashley Kuehne, LPC-S, LCDC has explained to me the reasons why the use of clinical hypnosis is recommended as a potentially beneficial strategy in my treatment. She has also explained that there are other options available to me should I not choose to give my consent to use clinical hypnosis. I understand that clinical hypnosis is a process during which changes are suggested in sensations, perceptions, thoughts, feelings, or behaviors and which consists of receptive concentration, focused attention, heightened awareness, and at times varying degrees of relaxation. I understand that persons experience clinical hypnosis in an individual way and that clinical hypnosis is a process which Ashley Kuehne, LPC-S, LCDC will facilitate but of which I am in control and can initiate and/or terminate for myself. Ashley Kuehne, LPC-S, LCDC has provided me with an explanation about the nature of clinical hypnosis, common misconceptions about clinical hypnosis, and the fact that sometimes exploratory clinical hypnotic procedures may create some degree of emotional distress. I have had an opportunity to have any questions concerning the use of clinical hypnosis answered to my satisfaction. I understand that clinical hypnosis will be facilitated by Ashley Kuehne, LPC-S, LCDC in accordance with applicable current ethical principles of the American Society of Clinical Hypnosis (ASCH).

The Nature of Memory

Memory is imperfect, whether or not clinical hypnosis is used. People have been shown to be capable of filling gaps in memory, of distorting information, and of being influenced in what is "remembered" by leading questions or suggestions of others. Research has demonstrated that there is no guarantee that information remembered through clinical hypnosis or through other means of recall is factually accurate. Thus, if you should remember something through clinical hypnosis, regard this information as simply one additional source of information that cannot be relied upon as more accurate or necessarily superior to material already in conscious awareness. Such additional data would be information to be weighed and evaluated in treatment along with what you already consciously know. Memory and clinical hypnosis researchers generally agree that it is inappropriate to confront someone in or out of court based solely on information retrieved through the use of clinical hypnosis.

Potential Legal Issue

In many jurisdictions, courts have held that a person who has utilized hypnosis may not testify in court about anything remembered during, or as a result of, the use of hypnosis. Consequently, if you consent to the use of clinical hypnosis, there is the possibility that anything you remember, once the work with clinical hypnosis has begun, would not be admissible in a court of law. The only way to absolutely protect your potential right to testify is to forego the use of clinical hypnosis. If you believe that there is some reason to anticipate that memories retrieved through clinical hypnosis might have legal consequences or implications, please inform Ashley Kuehne, LPC-S, LCDC immediately and prior to beginning the use of clinical hypnosis.

Release from Liability

The potential legal issue noted above has been explained to me by Ashley Kuehne, LPC-S, LCDC. I understand that, because of rulings of some legal authorities, there may be limitations placed on my ability to rely on my recollections during and/or after the use of hypnosis for purposes of litigation. I hereby agree, freely and voluntarily, to the use of clinical hypnosis in my treatment. I further agree to release and hold harmless Ashley Kuehne, LPC-S, LCDC from any claims or liabilities arising from the use of, or inability to use, my recollections, therapist's notes, or any other limitations on my, or my treating clinician's, testimony in a courtroom or forensic setting.

_____ _____

Printed Patient Name Patient Date of Birth

_____ _____

Patient Signature Date

Client Name Date

INFORMED CONSENT FOR THE USE OF EMDR IN TREATMENT

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a treatment approach that has been widely validated by research for Post Traumatic Stress Disorder (PTSD) and other applications such as anxiety, phobia, and many more.

I have also been specifically advised of the following potential risks:

Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients have experiences reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations. Subsequent to the treatment session, the processing of incidents / material may continue, and other dreams, memories, flashbacks, feelings, etc. may surface.

It has been explained to me that certain neurological disorders, such as epilepsy or other seizure disorders, are contraindicated with the use of EMDR.

It has been explained to me that I should not proceed with EMDR without legal consultation if I plan to testify in the court of law regarding a specific event and / or memory that will be discussed during EMDR treatment.

Before commencing EMDR treatment, I have thoroughly considered all of the above. I have obtained whatever additional input and / or professional advice I deemed necessary or appropriate in order to participate in EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment. My signature on this Acknowledgement and Consent form is free from pressure or influence from any person or entity.

With this knowledge, **I VOLUNTARILY CONSENT** to the above procedures, realizing that no guarantees have been made to me by Ashley Kuehne, LPC, LCDC regarding improvement of my condition by the performance of the above procedure.

I, hereby release Ashley Kuehne, LPC, LCDC from any and all liability, which may occur in connection with the results of the above procedures except when performed without appropriate care.

I understand than I am free to withdraw my consent and to discontinue my participation in EMDR treatment at any time.

_____ _____

Printed Patient Name Patient Date of Birth

_____ _____

Patient Signature Date