Finding Hope Counseling Services, LLC

14741 Highway 16 W, Philadelphia, MS 39350 (Primary office)

279 W Beacon Street, Philadelphia, MS 393 (Secondary Office)

Email: findinghopecs@gmail.com

About Finding Hope Counseling Services, LLC

As a private practice clinic, we believe that no one should be denied the ability to see a therapist and obtain help regarding their mental health for any reason. By this, we offer a sliding scale for those with no insurance. For families that are low income and cannot afford insurance or do not qualify for state assistance with insurance, we provide an application for financial assistance to help reduce the cost further.

It is our mission to assist those of our community as best as we can by ensuring that they do have options for effective treatment for various situations that they are facing in their lives.

Currently, we presently work with families, couples, children, and adolescents who are experiencing trauma, behavioral problems, impulse control, relational problems, interpersonal problems, and others along these lines.

I have read and understand that counselors at Finding Hope Counseling Services, LLC see a variety of clients and is willing to see clients of all ages who are willing to seek assistance.

Initial: __________

Counseling Services

The goal of Finding Hope Counseling Services is to provide a safe environment for clients to meet with their therapist. The purpose of creating a safe and calm environment is to provide clients the chance to express their emotions, or feelings, along with addressing any issues they are experiencing to help provide adequate care and assistance.

The intake session will be approximately 60 minutes to gather information. Session hereafter will be approximately 45 to 50 minutes.

If meeting with a child, parents can meet with either at the beginning or end for 15 minutes to provide insight into what is taking place within the home/school/community setting. Progress can be discussed during this time as well. "Homework" may be assigned for the child/adolescent to work on outside of therapy. It is understood that everyone is busy and that it may not be completed, however, it is requested that an attempt be made.

Family/Couple sessions will last approximately 50 minutes. Each week, "homework" will be assigned for the family/couple to work on in order to attain the goals established during the intake session.

"Homework", as previously stated, may be assigned and this is to help improve the understanding and use of the skills discussed in therapy each time.

Please be aware that therapy takes time and may cause feelings of discomfort. If these feelings arise, please feel free to discuss them with your therapist.

I have read and understood the way sessions will take place regarding therapy with a counselor at Finding Hope Counseling Services, LLC.

Initial: __________

Your Rights as a Client

1. If a clinician is seeing your child, you have the right to be involved and informed about your child's treatment and ask questions about the therapy process and interventions used in therapy.
2. You have the right to discontinue services with me as a provider at any time, for any reason. I will be willing to provide information for other counseling professionals that you might find to be a better "fit" for you, your child or family. I would ask that if you feel there is an issue with yours, your child's, or family's therapy process that you make me aware of your concerns so that we can attempt to work together to resolve the issue before seeking the services of another provider.
3. HIPPA law provides you with rights regarding clinical records and disclosure of protected health information (PHI). These rights include requesting amendments of your child's record, requesting restrictions on what information in your clinical records is disclosed to others, requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected health information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Informed Consent & Office Policies Agreement.

I have read and been advised of my rights as a client and have been given a HIPPA disclosure.

Initial: __________

Confidentiality

With some exceptions, everything discussed in therapy is strictly confidential and will not be shared with any other person or agency without your signed consent. Information will be shared with your insurance company for the purpose of processing your claims.

There are a few exceptions to confidentiality that are mandated by law which would require me to break confidentiality without you or your child's consent:

1. Threats of serious harm or death to another person where I assess that you or your child is at imminent risk of carrying out these threats. I will immediately notify you as a parent/guardian. I am required by law to inform the intended victim and notify appropriate legal authorities.
2. Threats of serious harm to self or suicidal ideation/gestures where I assess that you or your child is at imminent risk of acting on these threats or thoughts. I will immediately notify you as a parent/guardian or a trusted friend/family member. I will discuss the needed course of action for your child with you or a family member/friend regarding yourself, and further steps of additional assessment and hospitalization may be needed.
3. Revealed information related to child, elder (over age 60) or other vulnerable adult abuse or neglect. I am required by law to report this to the Department of Human Services.
4. If you are involved in a court proceeding and do not wish for your information to be shared, I can refuse to do this due to therapist/patient privilege. However, if a judge issues a subpoena, I am legally required to release information requested to the court system.

I understand the definition of confidentiality, and am aware of the situations in which staff at Finding Hope Counseling Services, LLC would have to break confidentiality with my child or my family. Initial: ___________

Fees and Insurance

The credentialing process is underway with several major insurance companies; however, this process can be lengthy depending on the processing speed of each insurance panel. We will be seeing cash pay clients during this process and the rates will vary based upon your income for each session. Your insurance information will be taken at your intake appointment and notify you immediately when approval as a network provider for your insurance occurs. We will then bill your insurance provider for your convenience. At that time, you will become responsible for copayments, coinsurance, meeting your deductible, and any other fees, expenses, or costs incurred that are assessed by your insurance provider. I will accept cash, checks, and credit/debit cards as payment for services. In the event of nonpayment, I may utilize the services of a collection agency to obtain payment for services, which may then include collection or attorney fees. You will also be unable to schedule yours or your child's next appointment until payment is received. There will be a $35 fee for returned checks.

I have read and understand how fees are assessed for therapy. I understand that there is a $35 fee for a returned check. I understand that my account or my child's account must be current to continue to schedule therapy appointments. If using insurance to cover cost of my visit, I

understand I must pay copay/meet deductible/pay any other fees assessed by my insurance in association with using this benefit.

Initial: __________

Legal Involvement

We do work with families who are engaged in legal issues; **however, we prefer to maintain any requested correspondence with the court system via letters of report of professional opinion**. In some cases (typically those involving children in DHS custody due to abuse or neglect), we are willing to appear in court without charging a fee. However, the practice does reserve the right to bill at a rate of $200 dollars an hour for court services, including situations where one of the therapists is subpoenaed by a judge. If you have a unique legal situation, please advise me so that we can discuss it and determine if you qualify for pro bono court appearance. If the practice deems that you do, we will sign a waiver that will ensure that no court costs are assessed to you.

I have read and understand that Finding Hope Counseling Services, LLC may elect, at the discretion, of the owner to provide pro bono court appearances. I understand the rate associated with a therapist employed at FHCS appearing in court.

Initial: __________

Late Cancellations, Tardiness, and No-Show Policies

The role as a mental health service provider for our clients very seriously. For our clients to benefit from therapy, it is important to attend all scheduled therapy appointments. Also, please remember when scheduled, your appointment states that you are reserving time on the clinician's schedule; therefore, if you do not keep your appointment, you may have taken an available time from another client needing a session. If for any reason you are unable to attend your scheduled appointment, **I require at least 24 hours of advance notice to inform me that you will not be able to keep your appointment. I will charge a late cancellation fee of $50 for appointments missed without proper notice given starting after the second late cancellation. A no-show for an appointment will also incur the same $50 fee and will take place after the 2nd no show.** Your insurance will not cover this fee and you will not be able to schedule another appointment for yourself, child, or family until this fee is paid. **If you realize that you are running late for an appointment, please contact me so that I am aware of the situation. If you will be more than 15 minutes late, please be advised that the appointment must be rescheduled.**

I have read and understand the policies for late cancellations, no shows, and tardiness. I understand that a late cancellation or no show for an appointment will result in a $50 fee. I understand that tardiness of 15 minutes or more will result in cancellation of that day's session.

Initial: __________

Office Hours and Communication

Normal office hours are Monday through Thursday, 9 am to 7 pm and Friday 8am to 12pm. Feel free to contact me by during these hours and leave a message if you need to speak with me regarding your therapy or that of your child. Your call or email will be returned within 24 hours, except for calls made after 12:00 P.M. on Friday. Calls made or emails received after 12:00 P.M. on Friday or over the weekend will be returned the next business day. We offer a call/text reminder service to help prompt you regarding your appointment. We do also offer limited weekend hours based upon the schedule of one of our clinicians. **However, if you do not receive a reminder, you are still responsible for attending the scheduled appointment or cancelling with at least 24 hours of advance notice.** Please be aware that due to the nature of current technology, email and text correspondences may pose confidentiality risks.

I have read and understand the appropriate manner for contacting a therapist at FHCS and am aware of the time frame my communication will be returned in.

Initial: ___________

I would like to receive text reminders regarding appointments, and I understand possible risks to confidentiality with this method of communication.

Initial: ___________

Emergency/Crisis Services

In the event of an emergency, it is unlikely that one of our clinicians will be immediately available to speak to you. **If it is a life-threatening emergency, call 911 immediately or go to your local hospital for an evaluation. You can also contact the local Crisis Line or National Suicide Hotline by dialing 988.** Please contact our office so that we are aware of the situation. Please also contact us in the event of non-life-threatening crises if you feel you need my assistance. We can conduct a crisis session for your child or family as quickly as my schedule permits.

I understand the procedures detailed for handling life threatening and non-life-threatening situations. I understand that FHCS, will attempt to schedule an extra appointment regarding a non-life-threatening crisis, schedule availability permitting.

Initial: ___________

Social Media/Social Interaction Policy

In our increasingly "connected" world, social media platforms are widely used by many individuals. However, in order to fully ensure confidentiality and privacy for my clients, **We prefer to not connect/add/link online with any of our clients or their parents.** This is

done to protect our clients.

Additionally, there may be times we see each other in public outside of counseling sessions. I will not address or identify you in public to protect your privacy. If you initiate conversation or contact, I will understand that you do not object to others potentially knowing that your child or family engages in therapy with me and will interact with you at that point.

I will not violate the social media policy. I understand the public page for Finding Hope Counseling Services, LLC on Facebook may be liked, added, and shared, if I so desire to. I understand the above policies are to protect my child and family's rights to private and confidentiality.

Initial: ____________

I have read and understand all the information contained in this document and I willingly consent to treatment of myself or child by Thomas E. Shoffner, LPC.

Client's Name:

____

Parent/Guardian Name:

____

Client or Parent/Guardian Signature:

____

Date: ________________________

***Unless revoked by parent/guardian, this consent is in effect for the duration of the treatment of the minor child patient. If your child has not been seen in session for a time period of 12 months or more, please be aware that a new initial intake session must be conducted in order to resume therapy services.**