Disclosure Statement, Informed Consent, Privacy Policies

Service Provider: Stacey H. Rosas – *Licensed Clinical Social Worker* – TX License: 51816

Provider Contact Information

(512) 522-4041 Phone
5900 Balcones Drive, Suite 100
Austin, TX 78731
rosaslcsw@gmail.com

Texas State Board of Social Worker Examiners

The practice of psychotherapy is regulated by the Texas Behavioral Health Executive Council and can be found online at https://www.bhec.texas.gov/. You can contact TBHEC with questions or concerns at the following address and phone number: 1801 Congress Ave., Suite 7.300, Austin, Texas 78701, or phone (512) 305-7700.

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Office Hours

Currently, I see clients via Telehealth Monday through Friday from 9:00 am – 3:00 pm (this may change without notice). If inclement weather occurs, I follow actions of the Austin Independent School District and will contact you to reschedule your appointment if/when delays or closings school occur.

Education & Degrees

Master of Social Work (MSW) – Direct Practice, Texas State University, 2008. Bachelor of Arts, Organizational Communication, California State University at Sacramento, 2002.

Independent Practitioner

As an independent practitioner, I am not legally or professionally affiliated with any other mental health professional or business.

Client Rights

You are entitled to information regarding my fees, methods of treatment, and the likely duration of treatment (if known). You have the right to obtain a second opinion from another therapist and can terminate treatment at any time. I welcome and encourage any questions or concerns you have surrounding your care.

The Therapeutic Process

To understand the nature of the therapeutic process and better anticipate what to expect, the following represents a partial list of answers to common questions and expectations.

- Psychotherapy is a collaborative effort between the you (Client) and me (Therapist). I can only facilitate change; I cannot make change happen.
- The change process can be uncomfortable.
- You may have insights, memories or otherwise gain information that may be unpleasant.
- You may experience loss in relationships as you discover and change behavior.
- Your family members and/or significant other may be reactive to changes you make as a result of psychotherapy.
- The therapeutic relationship is a very special professional relationship. While you may develop a close emotional bond with me, it is important to understand that this does not include a social relationship or friendship.
- Confrontation is an essential element of psychotherapy. You can expect me to reflect and confront issues, behaviors, and processes in as gentle and efficient manner as possible.
- The efficacy of psychotherapy - the power to produce results - is in the nature of the relationship between you and me. It is very important that you feel a comfortable and safe working relationship with me. While this takes time, it also requires that you be honest about your behavior and any concerns you may have about therapy or our working relationship.

Duration of Treatment

The length of your treatment will depend on a number of factors such as the intensity of your distress, the duration of your concerns, and how much time you put into your growth

between sessions. I am eager to collaborate with you openly about the duration of treatment. If I do not see you for a session for 60 calendar days, your file will change to a 'closed' status (or what's clinically called a 'terminated' status). You are welcome to contact me to return for treatment and your file will be 're-opened'.

Fee Structure & Financial Agreemen60

My fee for services is $185.00 per 55-minute session. My rate is subject to change. I will give you advance notice of any changes. My sessions last 55 minutes as I use the last five minutes of the hour to collect payment from you and schedule future sessions. This ensures we end on the hour to honor the next client's session; including your session. Payment is expected by the end of each session. I utilize a credit card system for payments and accept Health Savings Account (HSA) cards as well. I do accept some insurance but it is your responsibility to determine benefits prior to session. I encourage you to ensure I am an in network provider on your specific plan. If you have, are eligible for or might become eligible for Medicaid, it is your responsibility to tell me. If you become eligible for Medicaid and do not inform me in writing, you agree to pay any fees, penalties and reimbursements that may result. Delinquent accounts will result in termination of services. Trades, Barters and In-kind payments are not allowed. While the sentiment is appreciated, favors and gifts are not allowed. An appointment means that specific time is reserved for you. Late arrivals cannot be offered extra time, as it is reserved for someone else. If you arrive late, you will be charged the full fee for the shortened session. If you must cancel an appointment, please do so more than 24 hours in advance. If an appointment is missed or cancelled with less than 24 hours' notice, you will be billed the full amount ($185.00) of the session to be paid by the end of the next session. Please notify me as soon as possible if you know you need to re-schedule or cancel.

Social Networking & Dual Relationships

Dual relationships are not allowed. Once we have a therapist-client relationship, we cannot have a social, acquaintance, friendship or business relationship. Sexual intimacy between a client and therapist is never appropriate and should be reported to the governing board immediately. I do not have relationships with clients through personal social media (e.g. Facebook, Instagram, Snapchat). Due to this, I do not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you

have any questions about this issue, please feel free to discuss them with me.

Communications

It is my policy to do everything I can to protect client confidentiality and to comply with the Health Information Privacy Protection Act. Emailing and texting, while quite convenient ways to communicate with clients, are not secure means of communication. I make every effort to keep my phone and email private, however, it is possible for someone to break into or hack either my phone or email. Although I do text and email with clients who are comfortable with those means of communication, I do so only with the understanding on both sides that any information shared with me via text or email is not secured, does not meet HIPPA standards, cannot be guaranteed to stay private or confidential should someone attempt to break into or hack my phone or email, and that I do not conduct therapy by either text or email. For these reasons, I will not use email or text messages to discuss clinical issues (e.g. important things we talk about in session). If you are comfortable doing so, I am happy to use email/text to handle small administrative matters like scheduling and billing. If you are not comfortable with these risks, we can handle administrative issues via phone calls. If you opt to send a text message, please be mindful and text only during business hours.

Confidentiality & Communication Preferences

Please specify your preferences regarding communications with Stacey H. Rosas, LCSW. By providing this information and signing below, you give explicit, written authorization to Stacey H. Rosas, LCSW to respond to and initiate communication that may include Protected Health Information ("PHI") with you informed by these preferences.

Contact Preferences			
Please provide the following information:	Ok to call or write?	Ok to message? send/leave	Initial Choice
Mailing Address:			
Email:			
Cell Phone:			
Text (SMS):			
Home Phone:			

Work Phone:			

Emergency

In the event of an emergency, I can be reached at (512) 522-4041 during regular business hours. If I am in session, I will return your call at my earliest convenience. All clients will be notified in advance if I am out of the office for an extended period of time. If in an emergency arises, and you are unable to reach me, you should go to the nearest emergency room or Dial 911. For additional mental health resources, you can visit https://www.namiaustin.org/crisis-resources/.

Consent for Treatment

I **voluntarily consent** to mental health treatment with Stacey H. Rosas, LCSW. As the client, I (or parent/guardian) understand that **I have the right not to sign this form**. My signature below:

Client Name: _____

Client Signature: _____

Date Completed: _____

Client Information:

Name: _____ **Date**: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Birth Date: _____________ **Age:** _____ **SS #:** _____

Email: _____

Referred By: _____

Psychiatric Care:

Psychiatrist: _____

Address: _____

Phone: _____

Medications: _____

_____

_____

Diagnosis: _____

_____

Emergency Contact (18 years old and older):

Name: _____ **Date**: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Relationship: _____

I agree to be financially responsible for all fees incurred by me or on my behalf for services rendered by Stacey H. Rosas, LCSW. I understand that payment for services are due when rendered and that delinquency in payment will result in termination of services.

I acknowledge that I have read and fully understand the Informed Consent and Notice of Privacy Practices citing the procedures, privacy rules, fees for services, and confidentiality limits within a therapeutic setting. I understand that if a suit is filed to collect any unpaid balances on my account, I agree to pay the reasonable attorney fees for such procedures and I agree venue is acceptable in Travis County, Texas.

Client Name: _____

Client Signature: _____

Date Completed: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please read this notice carefully*.

Your health records contain personal information about you and your health. This information about you that may identify you and that 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) in accordance with applicable law. It also describes your rights regarding how I may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of the Notice of Privacy Practices. At that time, I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH 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 care, treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are as follows: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities**.** If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for the purposes of collection.

FOR HEALTH CARE OPERATION: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities,

licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g. billing or services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI, to remind you of appointments, to provide information about treatment alternatives or other health related benefits and services.

REQUIRED BY LAW: Under the law, I must make disclosures of your PHI to you upon request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule. **It is the practice of this office to obtain your authorization for disclosures of information. It is also your right to know that the following are examples where disclosures can and will be used, if necessary, without your authorization:**

Abuse and Neglect, Judicial and Administrate, Proceedings Deceased Persons, Emergencies, Family involvement in care, Health Oversight, Law Enforcement, National Security, Public Health, Research, Public Safety (Duty to Warn)

WITHOUT AUTHORIZATION: Applicable law and ethical standards permit me to disclose information about you without authorization only in a limited number of situations. The types and uses and disclosures that may be made without your authorization are those that are:

1) Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as Licensing Boards or the Health Department.)
2) Required by Court Order
3) Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

VERBAL PERMISSION: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to Stacey H. Rosas, LCSW.

1) **Right to Access to Inspect and Copy.** You have the right, which may be restricted, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost based fee for the copies.
2) **Right to Amend:** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
3) **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4) **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
5) **Right to request Confidential Communication:** You have the right to request that I communicate with you about clinical matters in a certain way or at a certain location.

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

NAME: **BIRTH DATE:**

_____ _____

(Print Name)

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices or my privacy rights. I can contact Stacey H. Rosas, LCSW at (512) 522-4041.

_____ _____

Client Signature Date

_____ _____

Signature of Parent, Guardian or Representative Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of attorney, healthcare surrogate, etc.)