Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

CONFIDENTIAL CLIENT INFORMATION

Name_____Birthdate_____Today's Date_____

Address_____City/State/Zip_____

Home Phone_____Work Phone_____Cell/Pager_____

E-mail_____

Employer_____

Household Members: Age: Relationship to Client:

_____

_____

_____

_____

_____

What prompted you to seek counseling at this time?

_____

_____

_____

Have you ever had counseling or psychiatric care in the past? If yes, when?

_____

In case of an emergency, please contact:

_____

Is there anything else you would like me to know?

_____

_____

_____

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

PROFESSIONAL TREATMENT POLICIES

Session Structure & Fees

Therapy sessions lasting 55 minutes are $145 per session. Sessions lasting 85 minutes are $225, and sessions lasting 115 minutes are $290.

If you need a reduced fee, please let me know, and we can discuss this.

Late Cancel Fees

If it becomes necessary that you cancel your appointment, please do so with at least 24 hours' advance notice. Clients will be billed in full for their session if cancellation is provided with less than 24 hours' notice. Please note that insurance does not cover missed sessions.

I do allow exceptions to late cancel fees. If I have an opening within the same M-F week as the appointment being cancelled and you are able to take that slot, I will waive the late cancel fee. Please be aware, however, that I may not have any other openings for the week, especially if the appointment being cancelled falls late within the week. Also, I will not bill you if you miss due to serious illness that would keep you from work or school.

Legal Appearance Fees

Please note that because I am extremely reluctant to appear in court, as such testimony does not generally benefit the client-therapist relationship, my fee for expert testimony in court or deposition is $750 per hour, whether appearing by agreement, or by commandment of subpoena, beginning when I leave my office to appear in court or deposition, to include all travel time, wait time and testimony time, whatever form they may take, and ending when I arrive back at my office. This fee is non-negotiable. If it becomes necessary that I appear in court on your behalf, I will provide you with a contract to sign for these services.

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

PROFESSIONAL TREATMENT POLICIES

Credit and Debit Card Payments

For credit card payments, I use an encrypted, online credit card system, which will store your card number for convenience. Even though it is encrypted, it is important that you know that credit card transactions over the internet are vulnerable to theft. If you choose to use a credit card, please initial here to approve my use of a credit card with which you will provide to me to charge for sessions, copays, deductibles, late cancel fees, and any other service you may request of me and that I provide. I accept Visa, Mastercard, American Express, and Discover credit and debit cards.

By **initialling**, I approve use of my credit card for the above-stated charges _____

Texting and Emailing

I do send appointment reminders by text or email, and I find emailing and texting to be a convenient way to communicate about logistical issues such as scheduling. However, please know that texting and emailing are not secure methods of communication, and should never be used to discuss counseling issues, and should never contain financial or personal information that would be tempting to identity thieves.

If you choose to text or email me, and if you are in need of discussing a counseling issue, I will respond to you with a possible time to meet for counseling, or to speak by phone.

It is your right to decline correspondence by email or text, including appointment reminders. You may choose to have all outside communication between you and I done by phone. Please indicate which methods of communication you approve by **initialling** the blank before it.

I approve communication by: _____Text _____Email

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

PROFESSIONAL TREATMENT POLICIES

Medical Care

I recommend that all clients seek medical consultation when experiencing mental health concerns. A medical doctor will be able to assess your physical health and inform you of any physical condition that may be contributing to your current concerns.

Individual Therapy with Children and Adolescents

If therapeutic care is to include counseling with a minor(s), please read and complete the following information. If not, please mark the section with "N/A".

_____ By initialing to the left, I, the parent or guardian of the below named youth, give consent for stated minor to participate in counseling sessions with Annette DelCanto-Ellington, LCSW.

_____ By initialing to the left, I, the parent or guardian of the below named youth, give consent to Annette DelCanto-Ellington, LCSW, or any associate or employee of Annette DelCanto-Ellington, LCSW, to administer basic first aid techniques in the event of an accident or injury. In the event of a serious accident, illness, or injury to my child, and in the event that a parent/guardian or other responsible party cannot be reached, I authorize Annette DelCanto-Ellington, LCSW, to seek medical care on behalf of my minor child.

Name of Minor:_____Date of Birth:_____

Physician:_____Phone:_____

Current Medications:_____

Current Medical Conditions:_____

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

Informed Consent Regarding Designated Executor to Professional Will

In my care of you as my client, I have a Professional Will in place wherein I designate an Executor to act as my representative in executing the professional responsibilities as they pertain to my license and private psychotherapy practice in the event of my death or incapacity. Part of those responsibilities would be to care for you as my client. Under those circumstances, my Executor would work with you to assist with the transition logistically, and to either take over the therapy with you or help you find a more appropriate therapist for you.

Please talk to me about any concerns you have regarding this clause. It is important to me that you feel comfortable with this policy, and understand that it is my intention to care for you, even after my death, as much as might be possible.

So that you know who might be contacting you, should my death or incapacity happen while you are under my care, I am providing you with the following information:

Appointed Executor is: Rich Armington, LCSW, CGP, SEP
armington@gmail.com
(512) 440-8910

Client Signature_____ Date_____

Client Printed Name_____

Therapist Signature_____ Date_____

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

CLIENT RIGHTS

1. Client is entitled to know therapist's credentials, training and experience.
2. Client has the right to ask questions about treatment at any time.
3. Client may terminate services at any time.
4. Client may refuse treatment, or any part of treatment, at any time.
5. Client is entitled to confidentiality about his/her identity and other information shared in sessions. There are, however, special and unusual circumstances in which this right to confidentiality may be waived. They are as follows:

    - If I believe client is in imminent danger to him/herself or to others;
    - When I am legally required to report abuse or neglect of children, disabled, or elderly persons;
    - When client provides written consent to release records and/or information;
    - If a court of law orders that I produce a client's records.

Additionally, at times I may feel it is necessary to consult with a colleague regarding your case in order to provide you with the best possible care. However, if I believe such consultation is necessary and choose to do so, your identity will not be revealed, and I will conceal any possibly identifying characteristics about you. Please inform me if you are uncomfortable with this policy, and do not wish for such consultation to take place.

ACKNOWLEDGEMENT AND ACCEPTANCE OF TREATMENT POLICIES AND CLIENT RIGHTS STATEMENT:

Policies and fees are subject to change. Current policies and fees are available on my website at www.annettedelcanto.com.

I have read and understand the above conditions as set out within the Professional Treatment Policies and Client Rights statements. I understand that if I have questions at any time, that I am free to ask questions.

_____ _____
CLIENT SIGNATURE DATE

_____
CLIENT PRINTED NAME

_____ _____
THERAPIST SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

Annette DelCanto-Ellington, LCSW
2525 Wallingwood Drive, Suite 701, Austin, Texas 78746
28465 Ranch Road 12, Dripping Springs, Texas 78620
512-426-6889; 800-939-2317 (fax)
annette@annettedelcanto.com
www.annettedelcanto.com

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 record contains 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"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also 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 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 that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE 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 health care treatment and related services. This includes consultation with clinical supervisors or 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 receive payment for the treatment 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 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, we will only disclose the minimum amount of PHI necessary for purposes 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, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose 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.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Annette DelCanto-Ellington, LCSW, 2525 Wallingwood Drive, Suite 701, Austin, Texas 78746:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **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. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Annette DelCanto-Ellington, LCSW, 2525 Wallingwood Drive, Suite 701, Austin, Texas 78746, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Annette DelCanto-Ellington's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Annette DelCanto-Ellington, LCSW, at 512-426-6889, annette@annettedelcanto.com, or by writing to her at 2525 Wallingwood Drive, Suite 701, Austin, Texas 78746.

_____
Signature of Patient/Client **Date**

_____
Signature or Parent, Guardian or Personal 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.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____
Signature of Staff Member **Date**