

**Kuadra Consulting Service, LLC**  
**Licensed Professional Counselor Provider**  
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## **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

**PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING YOUR COUNSELOR**

### **CONFIDENTIALITY**

Confidentiality means that therapists have a responsibility to safeguard information obtained during treatment. It is important that you understand that all identifying information about your and/or your child's assessment and treatment is kept confidential, except as noted below. In order to protect your and/or child's confidentiality, you must sign a release of information before any information about you and/or your child is given outside this office.

Should you elect to utilize health insurance (including any form of managed care) for services received, be aware that often insurance and managed care companies require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement is considered. Such companies may also request a copy of your and/or your child's records.

It is important that you understand that the laws of the State of Texas allow exceptions to confidentiality. In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, in these situations, I, as your therapist am not required to inform you of our actions. This includes the following:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

### **HEALTH INFORMATION PRIVACY POLICY SUMMARY**

The following is a summary of how you and/or your child's protected health information is used and disclosed and how you can obtain access to this information.

### **Uses and Disclosures of Health Information**

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you and/or your child receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

### **Your Rights as a Client**

Although your and/or your child's health record is the physical property of your therapist, the information contained in your and/or your child's health record belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your and/or your child's information
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your and/or your child's health record
- amend your and/or your child's health record as provided by regulation
- obtain an accounting of disclosures of your and/or your child's health information as provided by law
- request communications of your and/or your child's health care information by alternative means or locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

**Physical Health:** Physical health can be an important factor in the emotional wellbeing of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. As a routine part of the initial session, you will be asked the name of your physician and to list any medications that you are currently taking. In addition, a medical referral may be suggested if a medical problem is suspected.

### **REFERRAL PROCEDURE**

If legal, health, social service or other physical health needs are identified, we will refer and link you with applicable programs and services. We will track referrals by contacting you to follow-up on referrals to ensure programs and services are responsive to your needs.

### **Complaint Regarding the Privacy of Your Health Information**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your and/or your child's records, you may contact me. You also may send a written complaint to the Department of State and Health Services.

### **Our Legal Duty Regarding the Privacy of Your Health Information**

I am required by law to protect the privacy of your and/or your child's health information, provide this notice about my privacy policy, and follow the information practices that are described in this notice.

### **THE BENEFITS OF COUNSELING**

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and /or a greater understanding of personal goals and values.

**Services Offered and Clients Served:** I approach counseling from an integrative approach based on the client's needs and the nature of the presenting issues. The approach that I frequently use based on the most common presenting issues is advanced integrative body, mind spirit healing, transactional approach, mindfulness therapy, guided mediations, breath work, intuitive readings and cognitive behavioral. I believe that change occurs through the development of a collaborative working relationship and through changing negative thoughts and behaviors that affect changes in actions. I work with clients of all backgrounds.

**Code of Conduct:** I am required by law to adhere to the Codes of Conduct for practices that have been adopted by the Licensed Professional Counseling Board Copies of the codes of conduct are available to you upon request.

### **THE RISKS OF COUNSELING**

To allow you to make informed decisions about your counseling, your therapist wishes to make you aware of certain risks involved in counseling. You may experience discomfort, such as anger, depression, or frustration during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. We do our best to assess progress and provide referral to other sources if that is deemed necessary and appropriate.

### **EMERGENCY CARE AND APPOINTMENT**

If an emergency situation should arise, you may seek help through nearest hospital emergency room facility or dial 911. If you have after hour critical needs that do not require the emergency

room, leave a message on our primary office telephone number at (210) 314-7687, and we will respond as soon as possible.

Appointments are scheduled within 24 hours from when the call is made. You can make an appointment by calling the main number at (210) 314-7687 or via the website at [www.kuadracs.com](http://www.kuadracs.com).

Counselors are also listed on psychology today website and network therapy. Appointments can be made via these websites at:

### **Psychology Today**

<http://therapists.psychologytoday.com/rms/name/KUADRA+Consulting+and+Counseling+Services,+LLC+San+Antonio+Texas+183229>

### **Network Therapy**

<http://www.networktherapy.com/khadijat-quadri/>

**Subsequent Appointments** are made at the end of each session and remainder call or text messaging are made 24 to 48 hours prior to the appointment date. Additionally, we will call to re-schedule for missed or cancelled appointments.

### **COST OF SERVICE**

The cost of initial intake service is \$160.00 and \$140 for subsequent sessions. Should you choose to use health insurance, you will be required to complete the billing information and provide insurance verification. Should the fee present an unusual hardship, you may speak with your counselor about this during your initial visit.

### **PAYMENT OF FEES**

All fees for counseling are to be paid when the service is rendered. I accept cash and personal check. Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, this is your responsibility to pay. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits; and your counselor is not allowed to call for you. If you fail to obtain this authorization prior to your initial counseling session, some insurance companies reduce or decline reimbursement. In this event, you are responsible for payment.

### **INSURANCE CLAIMS**

All services rendered are the financial responsibility of the client or the client's parent or guardian. The client is responsible for the payment regardless of insurance coverage. Billing information will be provided to expedite client reimbursement from private insurance carriers.

**Authorization of Payment:** I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

**CANCELLATIONS**

**Cancellations must be made twenty-four hours in advance to avoid charge. Missed appointments will be charged at the regular fee.**

**NSF CHECKS AND REJECTED CREDIT CARD CHARGES**

**There will be a \$35 charge for each NSF check.**

**WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING**

I have reviewed this Counseling Agreement, including the summary of Privacy Policy. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

I accept this agreement and herewith consent to counseling.

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Client or Parent/Legal Guardian/Legal Representative Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Counselor Signature\_\_\_\_\_

