MARK S. DEBORD, LCSW, LLC
212 CYPRESS STREET
WEST MONROE, LA, 71291
318-381-9070

COUNSELING AGREEMENT

Psychotherapy or counseling is a process of growth and problem solving. It is an effort that requires sincerity, hard work and commitment from the client(s) and the therapist.

My commitment to you is to use my knowledge and skills to assist you in meeting your specific needs. All information will be held confidential and treated within the HIPAA guidelines and other applicable laws. Your personally identified health information may be disclosed for treatment purposes, to obtain payment for treatment provided and as necessary for the operations of the practice of Mark S. DeBord, LCSW, LLC. These uses and disclosures are more fully explained in the Privacy Notice that has been provided and that you have had the opportunity to review. You may request that Mark S. DeBord, LCSW, LLC restrict how your health information is used or disclosed. Mark S. DeBord, LCSW, LLC does not have to agree to the request, but if the agency does agree, it is bound by the restriction as agreed. In general, my practice is to ask for a release prior to disclosing any information.

Appointments cancelled at least 24 hours in advance shall be assessed no fee. Those canceled the same day may be assessed a $40 fee and those missed may be assessed a $60 fee (exceptions may be made for extreme circumstances). It is requested that clients expect to pay for services when rendered. Non-payment, delayed payment and repeated billing for delinquent accounts will only result in increased fees for everyone.

I anticipate our work together will be productive, but no guarantees or assurances can be made as to the results that may be realized, as there are numerous influencing factors. If you think this therapy or counseling is not meeting your needs, I encourage you to bring this to my attention without delay in order that adjustments or explanations may be made. I believe that our mental/ emotional health affects our spiritual health and vise versa. My preference is to use both behavioral science principles and Christian principles to maximize benefits. Please indicate below your preference by initialing below:

____ I would like counseling based on both behavioral science principles and Christian principles.
____ I have a different spiritual background and would like counseling with those beliefs taken into consideration.
____ I would like counseling with no special emphasis on spiritual health.

By my signature below, I hereby agree to the following:

1. I consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.
2. I give my consent to the provider and its agents to use or disclose my protected health information (PHI) to carry out treatment, payment, or health care operations. The provider may release, use, or disclose my PHI to other health care personnel including, but not limited to, physicians, nursing staff, physician assistants, child life specialists, physical therapists, occupational therapists, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the provider, his practice group, and their respective agents.
3. If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers.
4. I agree, as part of this consent for payment operations, that the provider, his group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of

the calling person and the calling person provides my correct social security number and/or health plan number.

5. I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations. I also agree that similar messages may be left with someone who answers the phone at any of the numbers provided.
6. I understand the limitations of electronic communication privacy. Emails are stored, text messaging can be stored and wireless communications can be intercepted. Additionally such electronic communications may be viewable by others if they intentionally or unintentionally have access to personal electronic devices and/or accounts. With this understanding and the understanding that the provider will attempt to be as discreet as possible; I prefer the following methods of communicating with the provider and grant permission for the provider to use the following forms of electronic communication with me or others who may be involved in my treatment: ____ FAX ____ Cell Phone ____Text Messaging ____ Telemed Service ____ Email for appointment reminder sent from Electronic Health Record (Practice Fusion)

   Email Address:_____
7. I agree that the provider may discuss my PHI with any person that accompanies me to a session or consultation or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional or spiritual care, including, but not limited to family friends, clergy, and patient advocates. I also agree that the provider, his practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly for my medical treatment.
8. If applicable, I agree that the provider, his practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.
9. I agree that the provider, his practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

I, _____, have read, understand and agree to the stipulations above and give my consent to receive therapy or counseling. I understand that I am responsible for the payment of my assessed fees. I have received or had opportunity to view a copy of the Statement of Rights and Responsibilities, Professional Disclosure Statement, Notice of Privacy Practices, Electronic Communication Policy, Discharge Process Policy and Emergency Contact Information.

This consent will remain in effect commencing on the date of admission until I have been discharged and/or fees have been settled. I understand that I have the right to revoke/ withdraw any part or all of this consent in writing at any time. My revocation/ withdrawal will be effective upon being presented to Mark S. DeBord, LCSW, LLC except to the extent that the agency has already taken action in reliance on my consent for use or disclosure of my health information.

Client: _____ Date: _____

Witness: _____ Date: _____

Parent/Guardian/Rep: _____ Date: _____

Revised: 04/16/2017