Rolling Plains Counseling & Wellness Center, LLC

Children, Adolescents, Adults
1510 15th Street
Wellington, Texas 79095
(806) 447-0147

Owner/Counselor: Tina Souder, M.Ed., LPC-S
Counselor: Mely Burch, M.S., LPC
Karen Rothwell, M.Ed., LPC
Lisa Koepke, M.Ed., LPC

rollingplainscwc.com

Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

Mobile Phone (guardian): _____ Permission to Text: ( ) Yes ( ) No

Email Address (guardian): _____ Permission to Email: ( ) Yes ( ) No

Language Preferred: _____ School: _____Grade: _____

Primary Care Physician: _____ Phone: _____

Referred By: _____ Phone: _____

Parent/Legal Guardian: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Parent/Guardian Date Of Birth: _____

Parent/Legal Guardian's Current Employment: _____

Work #: _____ Is it okay to call you at work? ( ) Yes ( ) No

Whom may we contact in case of an emergency? _____

Relationship: _____ Phone: _____

For patients with insurance:

****

Did you call your insurance company to preauthorize your visit today? ( ) Yes ( ) No

Insurance company: _____

Policy Holder: _____ D.O.B.: _____Employer:_____

Member ID #: _____ Group ID#: _____

Authorization #: _____

****

HOW WILL THIS BE PAID TODAY? PLEASE CHECK ONE:

CASH ____ INS. ____ MEDICARE ____ CPS ____ PROBATION ____ MEDICAID ____

Does your child have any health problems? If so, please list them below:

_____

_____

Is he/she currently on any medication? If so, please list them below:

Medication Name	**What symptoms is it for**	**Dosage**	**Prescribing Physician**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any family members in treatment currently at Rolling Plains Counseling & Wellness Center?

Name	**Relationship**	**Therapist**
_____	_____	_____
_____	_____	_____

Please name all persons with whom you currently live: (write on back also if you need to)

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are drugs or alcohol an issue? Yes ____ No____; If so, briefly explain.

_____

_____

What problems are you hoping to address in treatment here? What do you want to change?

_____

_____

_____

How long have you been dealing with this problem?_____

What symptoms are the most worrisome to you as a parent (i.e. can't sleep, worrying)?

_____

What are you doing to help your child cope now?

_____

_____

Has this problem/symptom occurred before? _____

_____

Have you or other family members ever been treated for this problem/symptom before?

_____

Has your child ever been in therapy before? _____ If so, please list:

When:	**With Whom:**	**To address the problem of:**
_____	_____	_____
_____	_____	_____

Have you or your child ever been hospitalized for psychiatric reasons before? _____

If so, please explain the circumstances: _____

_____

Are you dealing with any legal problems (i.e. custody dispute, probation)? _____ If so, please explain:

_____

_____

Is this consultation a part of addressing the above legal problem? _____

_____

Do you have any questions for your therapist? _____

_____

Date: _____

Patient Name: _____ D.O.B._____

Name of Person completing this form: _____

INFORMED CONSENT DISCLOSURE, EVALUATION, & TREATMENT CONTRACT

Welcome to the Rolling Plains Counseling & Wellness Center mental health practice owned by Tina Souder, M.Ed., LPC-S. If you would like, the counselor you are scheduled with will provide you with a copy of their Curriculum Vitae, which means the places they have received their degrees and the continuing education received. Associates are supervised by Tina Souder.

CONFIDENTIALITY

Communications made during evaluation or therapy visits are to be kept confidential. I will endeavor to follow your wishes on this subject, as you are the one who generally controls this information. However, I must make you aware of those few circumstances where I am compelled to breach this important promise. If you are the parent of a child, this applies to your child also.

In the event that our therapy session or evaluation reveals any information concerning the abuse of either children or senior citizens, I am mandated, by law, to make a report to the proper authorities. By the signing of this document, you acknowledge your awareness of these facts.

Additionally, if the course of therapy reveals any intent to harm yourself or others, you acknowledge my moral and legal duty to prevent you from bringing this harm about. I specifically have your irrevocable permission to warn those parties I feel possibly may be harmed. If you reveal an intent to harm yourself, I have your permission, also irrevocable, to prevent you from accomplishing your intent.

In the event you give consent for us to discuss your case with other health care providers or appropriate persons or agencies as directed by you, there is a release to be signed. This will often times include your medical doctor('s), or any prior treating therapist or possibly schools for your children as appropriate. I may also request a copy of the treatment records from these individuals or institutions. I will inform you if I feel the need to get this information. Also, I may ask you to gather this information from these professionals or institutions so that there is full cooperation with the intent to receive this information, which is solely for the purpose of diagnosis and treatment.

Lastly, if you are referred by court, state agency, or other agency such as the Department of Family and Protective Services or such; the agency relies heavily on the your physical, mental or emotional condition as a part of the claim or defense making the communication or record relevant to your treatment, thus for this reason you **waive the right to confidentiality.** (_____ initial). Reports, correspondence, oral communications, with the named agency are a customary part of this contract for evaluation or therapy.

I also give permission for my counselor to converse with other counselors in the group practice to provide the best possible treatment for myself.

I have read and understood the above limits to confidentiality.

Signed: _____**Date:** _____

ELECTRONIC COMMUNICATION

This office will not initiate communication using email, except with client permission when specifically pertaining to payment of services, or unless under usual circumstances (e.g., we are unable to contact you by any other means in an emergency). Your clinician will only use email communication and text messaging with your verbal and written permission by checking the appropriate item on page one of this intake. That means that email exchanges and text messages with this office should be limited to things like setting and changing appointments, billing matters and other related issues. Do not use PHI (personal health information such as name, date of birth, etc.) when using electronic communication, because access to electronic information is not assumed to be protected or private. Please be aware that use of email or texting for treatment-related issues are not secure and could be intercepted by third party persons. Please note that our support staff routinely reviews incoming email. They are bound by an agreement of employment by our practice that requires them to follow our HIPPA Policy and privacy practices.

I will send text reminders (email or voice mail if you prefer) of appointment times one day before the appointment time. Be advised that these reminders are not secure and there is a risk that they could be read by a third party. If you do not wish to receive these emails, please check no on the first page of this document.

RECORDS

It is state law that Rolling Plain Counseling & Wellness Center maintains a record of the treatment or evaluation given to you. This record will contain the information that will allow us to chart your course. We will use this record for that purpose only. It is my intent that no unauthorized person will ever see what is contained in this file. You may get a copy of the file only by providing us with a written information request. We may provide you with a synopsis of the course of treatment and outcome in lieu of the complete record. If the complete record is required, I will charge you for xeroxing the record. If you require a summary, then we will produce this at the usual fee per hour. This includes providing copies or reports to any court or legal representative or designate. In the event of your death, these requirements will be binding on any heirs, successors, or executor(s). In the event of my death, the records will be entrusted to my heirs, successors, or executor(s). In the event your counselor leaves the practice of Rolling Plains Counseling & Wellness Center, those records will remain in the custody of Rolling Plains Counseling & Wellness Center.

If the therapy sessions contain more than one patient, you agree that no one person may get the complete treatment file. I will attempt to maintain a separate record on each patient. However, only that individual is entitled to his or her own record. This is very difficult in the case of family therapy, couples therapy and assessments on children. In the case of combined records, you agree I may summarize the course of each individual's treatment as opposed to providing a copy of notes made during our therapy or evaluation sessions.

The laws of this state require that your record be maintained for a period of 7 years. I will maintain them for that period of time or whatever is statutory. At the end of that period, they will be destroyed. A minor child's records will be maintained for 5 years following the age of majority, then they will be destroyed.

If you have been referred by an insurance plan, company, or managed care organization. You must be aware that you may have waived your right to confidentiality as it pertains to the referring organization. If I am an approved provider for this organization, I may have to share all the information you provide with this organization. I will do as required to get you all the treatment that is appropriate. You should be aware that the organization might not be bound by my ethical and legal requirements on maintaining the confidentiality of your treatment or evaluation. By providing the required reports, you understand that I have no control over the use of the information made by the referring organization.

COST PER SESSION OR HOUR: Charges are based on one-hour units. Sessions range from 30 minutes to one hour. Pro-rated amounts may be considered at counselor discretion and availability

Tina Souder, M.Ed., LPC-S	1 unit=$150 Most Major Insurances accepted
Mely Burch, M.S., LPC	1 unit=$100 -- Most Major Insurances accepted
Lisa Koepke, M.Ed., LPC	1 unit=$75 -- UHC, Cigna, Aetna
Karen Rothwell, M.Ed., LPC	1 unit=$75 -- UHC, Cigna, Aetna

We will accept cash, check, American Express, Visa, MasterCard, or Discover

Cancellation Policy and Account Balance for Non-Medicaid Clients

We will try to give you advanced notice if we must cancel an appointment. We require a **minimum** of 24 hours cancellation notice from you if you must cancel. No-show/no-call will be charged a late fee of $50. If you cancel less than 24-hours before your appointment this too will be billed at $50 per missed session. Medicaid clients will be dismissed/referred after no-show or late cancel to two sessions.

It is our policy to charge a $50.00 fee for appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on our voice mail, which will note the day & time you called. For Monday appointments, cancellations can be left on our voicemail on the weekend 24 hours in advance. Your communication with our office about appointment cancellations allows us to offer that time to someone else who needs to be seen.

I authorize Rolling Plains Counseling & Wellness Center to keep my signature on file and to charge my credit card account for the following.

1. Balances of charges not paid within 30 days, but not to exceed $300.00.
2. Cancellation fee if an appointment is not cancelled within 24 hours.
3. If my card is declined for a no-show fee, I understand that the fee must be paid within 1 week or all future appointments I have scheduled will be cancelled.

I authorize balances for charges not paid within 90 days to be sent to a collection's agency.

Cardholder Name: _____ **Type of Card:** _____

Billing Address for Card:

_____

City: _____

Zip: _____

Credit Card Number:_____

Expiration Date: _____

Signed: _____

Date: _____

Other Fees

1. If report preparation is requested or required, the time rate charged for therapy sessions will apply.

2. Review of Provided Documents: Documents related to history, background information, school behavior, or testing are billed at the rate of $2.00 per minute.

3. Phone Calls: Only emergency phone calls are returned on a regular basis and only during office hours. These are billed per minute based on hourly rates & will be due at your next session. Review of Provided Documents and Phone Calls are not reimbursable by insurance.

4. Returned checks: There is a $25.00 charge on all returned checks.

Signed: _____

Date: _____

INSURANCE POLICY

You are responsible for full payment following each office visit. However, if your insurance plan has a co-payment you will be responsible to pay that co-payment. We will be happy to file your insurance claim for you. Associates do not accept insurance.

Most carriers require a provisional diagnosis in order to consider payment. For psychological evaluations, it is usually better to file claims after all evaluation, testing, and reporting is completed. Individual, group, or family therapy will be billed to your insurance company in a timely manner.

Please be aware that many insurance companies only pay for treatment of certain types of serious disorders and many have a number of disclaimers. This is especially true for children and adolescents. Hence, you or your child may not be covered. Thus, you will need to be prepared to pay your full bill in the case that your insurance carrier does not cover your services. Additionally, many carriers require precertification and multiple recertification procedures. To the extent humanly possible, please read your policy. Make sure that you have completed precertification when you come for care. Ask my staff to help you with this process if you are having difficulties. Additionally, when you have a co-pay please pay it at each session. Most insurance carriers do not allow us to bill these over time.

If you bring a minor child and share custody of this child with another guardian/parent, we must have a copy of the court order/divorce decree noting visitation and custody rights prior to the first session after intake. If another legal guardian is noted on the legal paper, then a name, phone number and address must be provided noting the contact information for the other parent/guardian. We will send the other parent a "Parent Letter of Participation" notifying them of their child's participation in counseling and encouragement to participate and receive reminders of appointments. If legal paperwork does not require both parties to give consent, sessions will continue, unless the other parent, after being notified of participation, notifies us that they do not consent to their child coming to counseling. At that time sessions will be stopped and not resumed unless it becomes court ordered. The parent/guardian bringing the child for services will be responsible for 100% of the bill and will be given receipts in order for them to provide copies to the other parent/guardian for reimbursement; unless other arrangements have been made with the office agreed upon by both parents. Any outstanding bills regardless of agreement is the responsibility of the initiating parent.

If we are not a contracted provider for your insurance company our policy is as follows: **We require you to pay for your services at the time they are needed.** We will provide diagnostic and procedural codes but you will need to file the insurance yourself.

Importantly, if we file an insurance claim that is correct and your insurance carrier has not paid in 90 days, we will ask you to pay your bill.

REPORTING POLICY

Many patients require written reports outlining evaluation findings and treatment recommendations. We are happy to provide, at minimal charge, a diagnostic summary including reasons for referral, tests, or procedures completed, DSM-IV diagnosis, and recommendations.

Comprehensive reports require a great deal of professional time. They may include more complete social history information, detailed analysis of test results, personality assessment, and treatment recommendations, usually taking at least 90 minutes. A minimum charge of $165.00 is customary for detailed reporting. If the report requires more than 90 minutes to prepare, the remaining time spent will be charged at $150.00 per hour.

Reports will not be forwarded to anyone other than the patient, patient's parent, or legal guardian without written release.

TERMINATION OF TREATMENT

The length of time required for evaluation and therapy will be determined by your personal situation. I will do my best to fulfill your therapeutic needs and provide you with my best professional care. For your part, you agree to participate in the process to the best of your ability. It is intended that when your needs are met, to the extent that they can be met, we will terminate our relationship. There is no guarantee of a cure.

For your part, **unless** court ordered, you may terminate my services at any time. This may be done in any one of these several ways. These include, but are not limited to, putting it in writing, informing me verbally, or failing to maintain your appointment scheduled without proper notification. I will respect your wishes. If you wish a refund to another provider please let me know.

If you do terminate therapy with me, it will be my decision as to whether we can re-establish our therapeutic relationship at a later date. Keep in mind that your decision to terminate therapy and the method chosen to accomplish the termination will impact any decision to resume a therapeutic relationship.

RISKS AND BENEFITS

It is important for an established therapeutic contract that any risks and benefits be addressed. Please inquire these. Additionally, if you are interested in alternative professional resources, it is important for you to discuss this initially, so you may have choices for your care.

PROCEDURES AND TIME FRAMES

In the case of psychological evaluation, please ask questions about what types of procedures will be included and the approximate time frames. Please be aware that we can estimate these sometimes very accurately. At other times, especially in complicated

situations, when the professional standard is to get multiple sources of information and/or data it may be more difficult to predict the length of time the assessment or procedure may take. Ask if you have any questions.

LICENSURE INFORMATION

All counselors affiliated with Rolling Plains Counseling & Wellness Center are under the jurisdiction of the Texas Behavioral Health Executive Council. The following is how contact the council in reference to complaints or questions:

Texas Behavioral Health Executive Council
333 Guadalupe St. Ste. 3-900
Austin, Texas 78701
(512) 305-7700

FORENSIC REPORTS

If your purpose in coming to my practice is to obtain a forensic evaluation and report, there are some very important differences you must be aware of. **This is not therapy, you are not my patient.** I have been hired to perform an evaluation and report my findings to a court of law or an agency. At a minimum, this means **the usual rules of confidentiality do not apply. By the very nature of our relationship, I will breach any confidence we may have.** This must be clearly understood. By signing this agreement, you acknowledge your understanding and agreement.

PAYMENT FOR FORENSIC WORK

I expect to be paid in full to the provision of any final reports. In some situations, **especially** those that are forensic, I require a retainer. This will be estimated to be equal to 50% of the total estimated cost of the evaluation. Prior to the final evaluation session, it is expected that the remaining balance be paid in full. The final report **will not** be released unless the entire cost of the process is paid in full. By your signing this contract you agree to be bound by this provision. _____ (Initials)

OTHER CONCERNS OR SPECIAL SITUATIONS

If there are other concerns you have, please mention these right away so we may address these.

_____

_____

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Date

Rolling Plains Counseling & Wellness Center, LLC
1510 15th Street
Wellington, TX 79095
(806) 930-9130 (mobile) 866-832-2587 (Fax)

Court Appearance Policy

I require a subpoena for court testimony or deposition. If the testimony will be by phone, my fee for phone testimony is based on $150 per hour. If I need to travel for testifying at court or for deposition, the charge is $150/hour, which will include travel time to/from the deposition or trial and time involved in preparation for the deposition or court appearance. I charge a retainer fee of $500 one-week prior to the trial or deposition if traveling 30 minutes from Wellington; $1000 if traveling an hour; and $1500 if traveling two hours or more. Should the total amount of time spent at the trial/deposition not exceed the stated retainer fee a refund of the difference will be given. However, if the charge is over the stated retainer fee, the difference will be billed and payment is to be received within one week of the trial/deposition. All fees are the responsibility of the party issuing the subpoena.

If you choose not to sign this document, please do not have your attorney subpoena me in you court proceeding. Each counselor also has the right to decline giving services if you choose not to sign. If your attorney subpoenas me, with or without your signature below, you will be responsible for the invoiced amount.

NOTE: Even though you are responsible for the testimony fee, it does not mean that testimony will be solely in your favor. Only the facts of the cases and professional opinion of your counselor can be testified.

_____ _____

Signature of Client or Legal Guardian Date

Please acknowledge receipt of this privacy notice by signing and dating in the space provided below. We will keep the acknowledgement in your record, and you may keep this Notice for reference. Thank you.

ACKNOWLEDGEMENT OF RECEIPT OF
ROLLING PLAINS COUNSELING & WELLNESS, LLC
PRIVACY PRACTICES

By signing and dating below, I acknowledge that I received a copy of Rolling Plains Counseling &Wellness Center's Privacy Practices.

_____
Patient Name

_____
Patient Signature or Parent/Guardian for Minor

_____
Date

NOTICE OF PRIVACY PRACTICES

Rolling Plains Counseling & Wellness Center, LLC
1510 15th Street
Wellington, TX 79095
Phone 806-930-9130

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GENERAL RULE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices

Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission, which is called an authorization form. In situations involving routine health care delivery, the law allows or requires us to disclose your health information without written authorization. Routine health care delivery includes treatment, payment and health care operations.

USES OR DISCLOSURES FOR ROUTINE HEALTH CARE DELIVERY PURPOSES
We use information for treatment purposes, when for example, we must set up an appointment for you or when our therapists provide treatment to you. It may be necessary to disclose your health information outside of our office for treatment purposes if, for example, we refer you to another provider for treatment. Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We use your health information for payment when, for example, our staff asks you about your health insurance information, or about other sources of payment for our services, when we prepare bills to send to you or your health insurance carrier, when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health care plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for health care operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our providers to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

USES AND DISCLOUSRES WITHOUT AUTHORIZATION
In some situations, the law allows or may require us to use or disclose your health information without your permission. Such uses or disclosures are:

- when a State or Federal law mandates that certain health information be reported for a specific purpose;

- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

- disclosures for judicial and administrative proceedings; such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

- uses or disclosures for health-related research;

- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- disclosures relating to worker's compensation programs;

- disclosures to business associates who perform health care operations for us and who agree to keep your health information private.

CONFIRMATION OF APPOINTMENTS

We may call to remind you of scheduled appointments.

OTHER DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to Tina Souder at the address or fax number shown at the beginning of this Notice.

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost incurred. If you want to ask for confidential communications, send a written request to Rolling Plains Counseling & Wellness Center at the address or fax number shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying, for example, "Psychotherapy Notes" have special protection under HIPPA and are not accessible by patients or insurance companies. For the most part however, you will be able to review or have a copy of your health information within 15 business days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Rolling Plains Counseling & Wellness Center at the address or fax number shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you

specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information Rolling Plains Counseling & Wellness Center, send a written request, including your reasons for the amendment to Rolling Plains Counseling & Wellness Center at the address or fax number shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Rolling Plains Counseling & Wellness Center at the address or fax number shown at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request, no matter whether you got one electronically or in paper form Rolling Plains Counseling & Wellness Center already. If you want additional paper copies, send a written request to Rolling Plains Counseling & Wellness Center at the address or fax number shown at the beginning of this Notice.

- Texas law permits access to a minor or elderly person's medical records by that minor/elderly person's parent and/or guardian.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Requirements until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new Privacy Practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will have copies available in our office.

COMPLAINTS/GRIEVANCES

If you think that we have not properly respected the privacy of your health information, you are free to make a complaint to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. If you would like to make a complaint to us, send a written complaint to Rolling Plains Counseling & Wellness Center, 1510 15th St. Wellington, Texas 79095 or scan and email the complaint to our office at tina.souder@soudercounseling.com.

I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

To report a rules violation by this licensee, contact the appropriate Board:

- Texas State Board of Examiners of Licensed Professional Counselors
- Texas State Board of Examiners of Marriage and Family Therapists
- Texas State Board of Social Work Examiners

At the following common address: Texas Behavioral Health Executive Council

George H.W. Bush State Office Bldg.

1801 Congress Ave., Ste. 7.300

Austin, TX 78701 (1-512-305-7700)

FOR MORE INFORMATION

If you want more information about or Privacy Practices, call or visit Rolling Plains Counseling & Wellness Center at the address or phone number listed at the beginning of this Notice.