DIANE LINDGREN, MA, LPC--S, NCC
2340 Trinity Mills Road, Suite 300
Carrollton, TX 75006
(214) 923-2174

PATIENT INFORMATION & OFFICE POLICY STATEMENT

I. WELCOME! *Thank you for choosing Diane Lindgren, MA, LPC-S, NCC. I would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.*

II. AIMS AND GOALS: *The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. Remember your progress in therapy depends on what you do between sessions, as well as what happens in your session.*

III. CONFIDENTIALITY AND PRIVACY: *Issues discussed in therapy are important and are generally legally protected as both confidential and privileged. However, there are limits and guidelines. They are described in detail in the attached "Notice of Privacy Practices".*

IV. APPOINTMENTS: *Appointments are usually scheduled for 45 minutes. Patients are generally seen weekly or more/less frequently as you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of a true emergency, you may reach your therapist at ((214) 923-2174). If you are unable to reach your therapist, please call your primary care doctor, 911, or go to the local emergency room.*

V. RECORD KEEPING: *A clinical chart is maintained describing your condition, treatment, and progress, along with dates of and fees for sessions. All active and inactive charts are kept on site, and in a locked cabinet.*

VI. PAYMENTS: *Payment is due at the time of the session, unless other arrangements have been made. We accept Cash, Debt, Check, or Credit Card (Visa, MasterCard, American Express and Discover.) As a courtesy to you, we will file your insurance claims, but you are responsible for all deductibles, co-insurance, and co-payments. Until your insurance benefits are verified, all visits will need to be paid in full. After we verify your benefits, then we will estimate the amount that the insurance will pay. This is ONLY AN ESTIMATE and the financial obligation for treatment is ultimately your responsibility. You will receive a bill for any outstanding balance. For insurance verification, filing and billing questions, please call Jo Bell at (817) 516-7019.*

VII. CANCELLATIONS AND MISSED APPOINTMENTS: *If you are unable to keep a scheduled appointment, you may leave messages 24 hours per day at (214) 923-2174. Insurance does not reimburse for failed appointments, therefore you will be billed for all sessions that were not canceled with at least a 24 hour notice.*

Patient Initials: _____

Diane K. Lindgren, MA, LPC-S, NCC
Frisco Professional Counseling, PLLC
2340 E. Trinity Mills Rd., Suite 300
Carrollton, TX 75006
214-923-2174

Notice of Privacy Practices

This notice describes how counseling information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to me.

LEGAL DUTIES: I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect (1/2/2009) and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make a significant change to my privacy practices, I will change this Notice and make the new Notice available upon request.

You may make request a copy of my Notice at any time. For more information about my privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF COUNSLEING INFORMATION: The above named professionals collect health information from you and store it in a written form or computer record. The medical record is the property of the treating professional. The information belongs to you. We use and disclose counseling information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: I may use or disclose your counseling information to a physician or other health provider oaring treatment to you.

PAYMENT: I may use and disclose your counseling information to obtain payment for services I provide for you.

HEALTHCARE OPERATIONS: I may use and disclose your counseling information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to my use of your counseling information for treatment, payment, or health operations, you may give me written authorization to use your counseling information or to discuss it to anyone or any purpose. If you give me the authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use this information unless as described in this Notice.

TO YOUR FAMILY AND FRIENDS: I must disclose your counseling information to you, as described in the Patients' Rights section of the Notice. I may disclose your counseling information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your healthcare but only if you agree that I may do so.

PERSONS INVOLVED IN CARE: I may use or disclose counseling information to notify or assist in the notification of (including or locating) family member, personal representative, or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to the use or disclosure of your health information, I will provide you with an opportunity to object to such uses of disclosure. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only counseling information that a directly relevant to the person's enrollment in your healthcare.

MARKETING HEALTH RELATED SERVICES: I will not use your counseling information for marketing communications without your written permission.

REQUIRED BY LAW: I may use or disclose your counseling information when I am required to do so by law.

ABUSE OR NEGLECT: I may disclose your counseling information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your counseling information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

NATIONAL SECURITY: I may disclose to military authorities the counseling information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials counseling information required for lawful intelligence, counterintelligence and other national security activities. I may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: I may use or disclose your counseling information (i.e. name and phone number) to provide you with appointment reminders (such as voicemail messages, postcard, or letter.

PATIENT RIGHTS: access: You have the right to look at your counseling information with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so (you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, I will charge you $30 for staff time to locate and copy your counseling information and postage if you want the copies mailed to you. If you request an alternative format, I will charge a cost based fee for providing you counseling information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of my fee structure)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances if we disclosed your counseling information for purposes other than treatment, payment, or healthcare operations and certain other activities for the last 5 years, but not before 1/2/2009. If you request this accounting more than once in 12 month period I may charge you a reasonable, cost based fee for responding to these information requests.

RESTRICTIONS: You have the right to request that I place additional restrictions on my use or disclosure of your counseling. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that I communicate with you about your counseling information by alternative means or to alternate locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location.

AMENDMENT: You have the right to request that I amend your counseling information (your request must be in writing and it must explain why the information should be amended). I may deny your request under certain circumstances.

ELECTRIC NOTICE: If you receive this Notice on my Wed site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

TEXT AND E-MAIL COMMUNICATIONS: Electronic mail (e-mail) or Text messaging may contain privileged and/or confidential information. Client understands that no e-mail or text is guaranteed to be safe and secure from illegally obtained access to the Client's or Counselor's e-mail or text account. Therefore, Client understands these risks when voluntarily choosing to use e-mail or text forms to contact said counselor.

QUESTIONS AND COMPLAINTS: If you want more information about my privacy practices or have questions or concerns, please contact me. If you are concerned that I may violated your privacy right, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your counseling information or to have me communicate with you by alternative means or alternative locations you may complain to me using the contact information listed at the end of the Notice. You may submit a written complaint to the US Department of Health and Human Services. I will provide you with the address to file your complaint with the US Department of Health and Human Services upon your request.

We support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the US Department of Health and Human Services.

I acknowledge receipt of this information and agree to the above conditions.

_____
Signature of Client or Representative

_____
Date

(Office Use Only)

If failure to obtain signature:

Client refused to sign: _____

Other reason: _____

Contact Information

Diane K. Lindgren
Frisco Professional Counseling, PLLC
2340 E. Trinity Mills Road, Suite 300
Carrollton, TX 75006

Diane K. Lindgren, MA, LPC-S, NCC
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Cancellation/No Show Policy:

When you set an appointment with a therapist, that time is reserved just for you. If you are unable to attend your appointment, I require clients to provide 24 hour notice. The notice offers the therapist time to give the appointment to antoher client. The cot for missed appointment is $50.00. Insurance cannot be billed for missed appointments and you are fully responsible for this charge.

I understand the cancellation policy and agree to give 24 hour notice for any cancellation. I further give Diane K. Lindgren, MS, PLC-S, NCC authorization to ill my credit card $50.00 for any appointments that I miss or that I fail to cancel according to policy.

Name (Please Print): _____

Client Signature, Parent/Guardian_____Date_____

Credit Card (Circle One)

Visa MasterCard AMEX Discover

Card Number: _____

Expiration Date: _____

Address: _____

Zip Code: _____

Security Code: _____

This information will be kept in your file in a locked cabinate.