Perspectives Counseling, Llc
Cindy Cole, MA, LPC/MHSP
106 Mission Court, Suite 302
Franklin, TN 37067
615-491-1877

Practice Policies

In order to answer common questions regarding fees, confidentiality, and services, I have established the policies below. I respect and value you as a client and I want you to have the information you may need as we proceed.

Fee Policy/Payment

My fee for counseling services is $150 per session (60 minutes). The initial intake session fee is $225 (90 minutes). In addition to the time we spend in session, this fee also includes the time I spend preparing before your session and completing paperwork after the session.

Please understand that appointment times are limited. **If you must cancel or reschedule your appointment, I respectfully request 24 hours notice.** Missed appointments, or appointments cancelled without 24 hours notice, will incur a fee of $75. In the event of sickness or an emergency, you will not be charged unless this happens multiple times.

I do not accept insurance. Fees are to be paid at each session. Payment for sessions can be made by check, cash, or credit card. Checks can be made payable to “Perspectives Counseling.”

Confidentiality/Client’s Rights

HIPAA provides you with patient rights regarding your Clinical Record and disclosures of Protected Health Information. You may request a copy of the HIPAA Privacy Notice at any time. Professional ethics and Tennessee State law indicate that confidential information is controlled by the client. Information shared in sessions with a counselor will be held in confidence. There are **a few exceptions** to this general rule:

(1) In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality.

(2) Tennessee law requires that child or elder abuse in any form be reported to the proper authorities.

(3) Additionally, the client’s behavioral health record may be compelled by state law to become part of a legal proceeding.

Text messaging and email are not secure methods of communication, and there is some risk that confidentiality could be compromised with their use. By signing below, you are saying that you have considered and understand the limits of confidentiality and agree that you are responsible for keeping your email and text messages private to the extent that you desire them to be private. Additionally, I strive to limit the use of text and email only to set up or cancel appointments. If you choose to correspond with me via text or email, beyond managing appointments, the messages and emails will be printed off and included in your records.

Professional Services
I DO NOT provide counseling via text or email and will not respond to clinical questions using this type of technology. If you have a clinical counseling concern, please bring it up at your next session.

I am not a certified Custody Evaluator or an Expert Witness, as defined by the legal system. I am not permitted to make any judgments on custody. In the case that I would be subpoenaed to court or involved in any legal matter, the client will be charged a fee of $300 an hour (this includes note taking, phone calls, writing case summaries, time in court, etc.). I do not testify unless required by a court order.

When client files are being requested, I will follow the General Rules and Regulations of the state of TN, which allow the counselor to determine if all records or a summary of service would be in the best interest of the client (0450-01.18 Mandatory Release of Client Records).

In the case of my death, incapacitation or termination of practice, my trusted colleague, Shari McClaren, LPC/MHSP (TN License #3085) will assume responsibility for the management of my client's therapy needs and records.

Clinical Emergencies
If you have a clinical emergency, please call 911 and/or go to the nearest hospital emergency room. I will be unable to respond to texts and emails in a timely manner, therefore do not text or email me when you are in a crisis and feeling suicidal, overwhelmed, or unsafe.

Benefits and Risks of Counseling
Persons contemplating counseling should realize that they might make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own decisions made in counseling, personal growth and/or changes that occur during the counseling process.

Social Media
I do not participate in social media with my clients. Since counseling involves a strictly professional relationship, I will decline any and all requests by clients to connect via social media.

Credentials
I am a Licensed Professional Counselor/Mental Health Service Provider in the State of Tennessee (License #3879).

Do you have any questions about fees, confidentiality, or other matters? **Yes ____ No ____**
Do you agree with the conditions and provisions of these Practice Policies? **Yes ____ No ____**
Do I have your permission to correspond with you via text messaging? **Yes ____ No ____**
Do I have your permission to correspond with you via email? **Yes ____ No ____**
Do I have your permission to leave you a voicemail message? **Yes ____ No ____**

Client Signature: ____________________________ **Date: ________________**

Perspectives Counseling, Llc
Cindy Cole, MA, LPC/MHSP
106 Mission Court, Suite 302
Franklin, TN 37067
615-491-1877

Client Intake Form

Name:_______________________________ Date: _________

Address: ____

City: __________________ State: _______ Zip: ________

It is customary for Perspectives Counseling practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

____

Phone: (H) ______________ (C) ______________

Email: ____________________________________

Preferred Method of Contact: Phone call or Email or Text message (circle one)

Age: ______ DOB: _______________ Religious Affiliation: _________________________

Employer: ____________________________ Occupation: ___________________________

Marital Status: Single/Married/Divorced/Widowed (circle one) How long? ______________

Spouse's Name: ________________________ Spouse's Phone: ________________

Children:	Name	Age
	_________________________	___________
	_________________________	___________
	_________________________	___________
	_________________________	___________
	_________________________	___________

Referred by: ____

Do I have your permission to thank the person who referred you? Yes/No

May I use your name, when I thank them? Yes/No

Mental Health Information

Have you ever seen a counselor or mental health professional before? If yes, please provide the following:

Dates Seen: _______________ Counselor Name: ___________________

Reason for previous counseling: ____

Was it helpful? Yes/No Why/Why Not? ____

Are you currently taking medication for a mental or emotional condition? Yes/No

Please list conditions and medications: ____

Any suicidal thoughts or attempts? (____ past or ____ present)

Do you currently use any alcohol or drugs? Yes/No

If yes, list amounts/frequency? ____

Are you in treatment (such as outpatient) or utilizing support groups (such as AA)? Yes/No

If yes, please describe: _____________________________________

What types of self-care practices have been helpful to you in the past when dealing with difficult situations?
Examples: journaling, exercising, workbooks, prayer, support groups…

____

Reasons for seeking counseling: ____

In a few words, what do you think therapy is all about? ____

How long do you think therapy should last? ____
How long are you able to commit to therapy? ____

What personal qualities do you think the ideal therapist should possess? __________________________________

Emergency contact information:

Name: ____

Relationship: ______________________ Phone: _______________

Client Signature: _________________________ **Date:** ________

Childhood and Family of Origin

Do you have any brothers or sisters?

Name	Age
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

What was your father like? What kind of relationship did you have with your father?

What was your mother like? What kind of relationship did you have with your mother?

As a child, how did you know your parents loved you?

As a child, how did you know your parents loved each other?

Were you ever abused as a child? (physically, emotionally, sexually)

General Health

Please list all medications currently taking:

Have you ever been prescribed sedatives to help you sleep?   Yes/No

Have you ever been prescribed medication to help with depression?   Yes/No

Have you ever been prescribed medication to help with anxiety?   Yes/No

Spiritual Inventory

What relationships have the greatest influence in your life right now?

Are there any persons from your past that have played a significant part in shaping your view of life? (If yes, please list each and why)

Has there been an event in your life (either positive or negative) that was so intense that it permanently affected your outlook on life? (If yes, please describe briefly)

Note: You can skip the remainder of the questions on this page if you do not want to discuss religious or spiritual issues in counseling.

Do you have a belief in God, a higher power, or other?

How would you describe your religious or spiritual beliefs and practices?

What role has religion and/or spirituality played in your life?

Is your faith/spirituality helpful to you? Yes Somewhat Not at all

Is there anything you do to help nurture or maintain your faith/spirituality?

Current Status

Please answer the following questions so that we might have a better idea of how you are doing (circle the correct number):

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7

Cindy Cole, MA, LPC/MHSP
106 Mission Court, Suite 302
Franklin, TN 37067
615-491-1877

HIPAA Privacy Practices

We are required by law to follow the practices described in this letter. This letter is a summary of our Privacy Practices, but does not replace the full version which has been made available to you. This notice applies to personal medical/mental health information that we have about you, and which are kept in or by this facility. With some exceptions, we must obtain your authorization to disclose (or release) your health care information. There are some situations in which we do not have to obtain your authorization. We can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Office for this facility.

Who Has Access To Your Personal Information?
Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social
- Services.
- Measure our quality of services.
- Decide if we should offer more or fewer service to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
  1. We did not create the entry
  2. The information is not part of the file we keep; or
  3. The information is not part of the file that we would let you see; or
  4. We believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years.
- The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example-not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other released of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

________________________________ ______________________

Client Signature **Date**

Perspectives Counseling, Llc
Cindy Cole, MA, LPC/MHSP
106 Mission Court, Suite 302
Franklin, TN 37067
615-491-1877

PAYMENT BY CREDIT CARD AUTHORIZATION

Name ______________________________________ **Date** _____________________

Address ____

City/State/Zip ____

Email ___________________________________

Cell Phone ______________________________

Payment By: **Visa** **MasterCard (Circle One)**

Credit Card # ___________________________

Expiration Date _______________ **V Code (3 digits)** _________

My signature below authorizes Perspectives Counseling, LLC to charge my credit card for counseling fees, missed appointments, and cancelled appointments that do not meet the cancellation policy of a 24 hour notice via a telephone call or text message.

Client Signature __________________________________

Date __________________________