**Jennifer Leister, LPC-S**
**17480 Dallas Parkway, Suite 230**
**Dallas, TX 75287**
**Phone:** **(469) 828-4603** **Email:** Jennifer@jennifercounseling.com **Fax: (972) 407-1305**

# WELCOME TO MY OFFICE

## POLICIES AND PROCEDURES
## CLIENT CONSENT FOR COLLABORATIVE LAW/PRACTICE SERVICES

I am glad that you are here, and I am committed to providing you with quality care. Please take a few minutes to read the following information that will explain my office policies and procedures to you. If you have any questions, please ask and I will be happy to clarify any of the information in this form. Please sign and date this form, acknowledging that you have read and fully understood the information and are consenting to my services as a member of your collaborative team in accordance with the executed Collaborative Law Participation Agreement. Please read the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and sign and date the form acknowledging that you have read and understood the HIPAA policies. Finally, please read and sign the attached waiver detailing potential risks to your confidentiality. Thank you.

**Qualifications:** Your Neutral Collaborative Mental Health Professional (MHP) is Jennifer Leister, LPC-S, a licensed professional counselor and a mediator. In this role I abide by the Ethical Guidelines of Mediators.

**Services:** Forensic Services are services ordered by the court, agreed to by parties in a court order related to a court case, or performed with a reasonable expectation that they will be the subject of a future court case. Collaborative Law is an alternative dispute resolution process, and as such is a forensic service defined by statute in the Texas Family Code, Title 1-A. The services that you are agreeing to are specified in the executed Collaborative Law Participation Agreement, which further explains my role and responsibilities as your Neutral Collaborative MHP.

Although my training, background and experience give me many tools to help you, the work we do in the collaborative process is *not* therapy or counseling and as your Neutral Collaborative MHP I am *not* your therapist. As we work together, if we decide that other services are needed, I will provide you with appropriate referrals. As a Neutral Collaborative MHP I cannot: make formal recommendations, make decisions, serve as a tiebreaker or testify in court. Once the process concludes successfully, the only other professional service that I can provide for your family, if appropriate and by your joint choice, would be as a Court Ordered Parenting Coordinator. If your collaborative process is not successful, and is terminated without resolution, I am disqualified from providing any ongoing services, and I can provide no future services to you or your family in any capacity. While benefits are expected from the collaborative process, specific results are not guaranteed and there are inherent risks. Together we will work to achieve the best results for you.

**Confidentiality:** The collaborative process is a confidential process, as determined and specified by statute in the Texas Family Code, as an alternative dispute resolution procedure. The parameters and conditions surrounding privilege and confidentiality are detailed in the Collaborative Law Participation Agreement (CLPA) that you have signed. As a brief recap, as a Neutral Collaborative MHP my records cannot be subpoenaed nor submitted into evidence in any legal proceeding. I cannot be deposed nor can I be compelled to testify regarding either of you or the collaborative process in any legal action in which you are involved. No information provided

during the course of our meetings will be revealed to anyone other than the other client in the process and the collaborative team members, unless allowed or mandated by law and then, only to the extent required by law. No information will be shared with other professionals, even at your request or with your permission, with the exception of educating other professionals about the collaborative process in which you are engaging, and then, only with your written authorization. Once the process concludes, either successfully or by termination, the only information that can be provided to you or any professional are documents that had previously been distributed to you and the collaborative team members prior to conclusion. Possible legal exceptions to confidentiality include, but not limited to, the following situations (please review the HIPAA Notice of Privacy Practices for additional exceptions):

- If you reveal information that indicates you are a danger to yourself or someone else necessitating a duty to protect or duty to warn
- If you reveal information about child abuse, neglect, sexual abuse or elderly abuse

**Duty to Warn/Duty to Protect:** <u>If Jennifer Leister, LPC-S believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Mrs. Leister to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger.</u>

**Federal Privacy Laws:** Under federal regulations, records related to forensic services are not heath care records and are not protected by federal privacy regulations. However, to the degree that I come into contact with mental health information pursuant to the Collaborative Law/Practice process, such information does fall under the Texas Medical Records Privacy Act and will be protected accordingly. Please review the HIPAA Notice of Privacy Practices for additional information. If you have questions about your privacy, which will be protected pursuant to the CLPA and these guidelines, please discuss them with me and/or your attorney.

By signing this Information and Consent form, you are giving consent for me to share confidential information with the other client, the collaborative team members and all persons mandated by law; you are releasing and holding me harmless for any departure from your right to confidentiality that may result.

We will be utilizing unencrypted email, but secure transmission, as a means of communication. I will provide brief summaries of our meetings outside the team (“offline meetings”) to you and the collaborative team members. Any type of audio/visual recording is prohibited in the collaborative meetings, or phone calls, without prior discussion and my consent.

If you have any questions or concerns regarding confidentiality, please discuss them with me before signing this form.

**<u>Appointments:</u>** Services are by appointment only and are typically scheduled between 9:00 am and 5:00 p.m. You are responsible for keeping your appointment and arriving on time. In the event that you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. If one of you is late for a joint appointment, the meeting will not begin until both of you are present, unless specifically addressed otherwise. Please help me serve you better by being responsible for keeping your scheduled appointments and being on time.

The telephone is answered either by the office manager or voice mail, so messages can be left 24 hours a day, 7 days a week. Due to my appointment schedule, it may be several hours before I can return your call. Calls received late in the day may not be returned until the following day. After-hours or weekend calls and emails are generally not returned until the next day or the following Monday as I do not check either voicemail or email after work hours or on the weekend.

**Emergencies:** You may encounter a personal emergency that may require prompt attention. Please contact my office and I will make reasonable efforts to respond to your emergency in a timely manner. If it is after-hours or on a weekend, or you reach the office voice mail during an emergency situation, please go to the nearest emergency room and ask for assistance, or call 911. When I am out of town, I will provide the name and contact information for an on-call clinician.

**Termination of Services:** If you decide at any time that we are not a good fit you have the right to address that concern with your attorney or the collaborative team members, however, neither you nor the other client can unilaterally terminate my services. Upon both of your agreement, however, and with the permission of the team, I can withdraw and in such circumstances I am willing to provide alternative recommendations for your Neutral Collaborative MHP.

**Financial Policy**: All "offline meetings" are approximately two hours, and are billed on a per session basis at the rate of $200 per hour. Sessions may be scheduled for shorter or longer periods of time and in such instances are billed on a prorated basis. If you call at least 24 hours in advance of your scheduled "offline meeting" to cancel, you will not be charged. If you provide less than 24 hours notice, there may be a full- or partial-fee charge, emergency situations notwithstanding. I will evaluate each such circumstance and a determination as to the charge will be made at that time. Joint meetings (those including all collaborative team members) are billed at the hourly rate for the amount of time scheduled. I do bill for any telephone conference, with you or other professionals, which require formal scheduling on my calendar. You will not be billed for *concise* phone calls regarding scheduling or other questions. However, I reserve the right to bill for excessive out-of-meeting communications, if that becomes a significant issue. I do not bill for reading or writing emails, but reserve the right to do so if the email demands become excessively burdensome and time-consuming. I will discuss all such situations with you in advance. I do bill for any telephone conference with you or other professionals (including collaborative team calls and collateral professional calls) which require formal scheduling on my calendar. If I am summarizing your parenting plan discussions in a memorandum of understanding, I charge my hourly rate. As addressed in the Collaborative Law Participation Agreement, I require a $3,000 retainer. If the retainer drops to $500, you will be notified and are expected to replenish it at that time. Upon successful resolution or termination, any remaining monies will be refunded to you and the other client. I accept cash, checks, MasterCard, and Visa. Returned checks will be assessed a $25.00 administrative fee for each occurrence. Please be aware that since my work as the Neutral Collaborative MHP is a forensic service, and I do not provide diagnoses, such services are not covered by insurance and you cannot file for reimbursement.

You are responsible for any legal fees that I incur as related to your case or my collaborative practice services.

I reserve the right to suspend services if there is an unpaid balance in your account.

**Incapacity or Death:** I understand that, in the event of my death or incapacitation, it will be necessary to assign your case to another Neutral MHP and for that Neutral MHP to have possession of my records. By my signature on this form, I hereby consent to Dr. Honey Sheff to take possession of my designated record set and provide me with copies at my request, and/or to deliver the designated record set to another Neutral MHP to be determined in conjunction with the collaborative team members.

Please be aware that I share office space, expenses and office staff with Ray Levy, Ph.D. and Dr. Honey Sheff. We are three independent professional practices and are not in any form of business partnership with each other.

**Consent to Collaborative Law/Practice Services:** By signing this Client Information and Consent Form as the Client I acknowledge that I have read, understand, and agree to all the terms and conditions contained in this

document and the related Collaborative Law Participation Agreement in this matter. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to have Jennifer Leister, LPC-S serve as the Neutral Collaborative MHP pursuant to the Collaborative Law Participation Agreement.

______________________________________________

Printed Name

__________________________ __________________________

Signature—Client Date

__________________________ __________________________

Jennifer Leister, LPC-S Date
Neutral Collaborative MHP

Attachment: CLPA

## Jennifer Leister, LPC-S

## Acknowledgement of Receipt of Notice of Privacy Practices

**Patient Name:** ________________________________________

**I hereby acknowledge that I have received a copy of Jennifer Leister LPC-S Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.**

____________________________________________________
**Signature of Patient or Legal Representative**

__________________________________
**Date**

____________________________________________________
**Printed Name of Patient's Representative (*if applicable*)**

**Relationship to Patient (*if applicable*)**
☐ Parent or guardian of un-emancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________.

Acknowledgment could not be obtained due to the following reason:

☐ Patient/representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
☐ Communication barriers prohibited obtaining acknowledgement (Explain)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

☐ Other (Specify)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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# Jennifer Leister, LPC-S
# NOTICE OF PRIVACY PRACTICES

**EFFECTIVE DATE:** September 23, 2013

**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.**

## UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

## YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

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## HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

**Treatment:** We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

**Payment:** We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

**Regular Healthcare Operations:** We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

**Appointment Reminders:** We may use and disclose protected health information to contact you to provide appointment reminders.

**Treatment Alternatives**: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

**Health-Related Benefits and Services:** We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

**Business Associates:** There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Worker's Compensation:** We may release protected health information about you for programs that provide benefits for work related injuries or illness.

**Communicable Diseases:** We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** We may disclose protected health information to federal or state agencies that oversee our activities.

**Law Enforcement:** We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

**Military and Veterans:** If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

**Lawsuits and Disputes:** We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

**Abuse or Neglect:** We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Fund raising:** Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

**Coroners, Medical Examiners, and Funeral Directors:** We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

**Public Health Risks:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

**Serious Threats:** As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Food and Drug Administration (FDA):** As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Research (inpatient):** We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

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## OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Jennifer Leister, LPC-S, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Jennifer Leister, LPC-S or with the Secretary of the Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

| **U.S. Department of Health and Human Services** | **Office of the Texas Attorney General Consumer Protection Division** | **Jennifer Leister, LPC-S** |
|---|---|---|
| Office of the Secretary<br>200 Independence Avenue, S.W.<br>Washington, D.C. 20201<br>Tel: (202) 619-0257<br>Toll Free: 1-877-696-6775<br>http://www.hhs.gov/contacts | PO Box 12548<br>Austin, TX 78711-2548<br>Tel: (512) 463-2100<br>Toll Free: (800) 252-8011<br>https://www.oag.state.tx.us/forms/cpd/form.php | Privacy Officer<br>17480 Dallas Parkway, Suite 230, Dallas Texas 75287<br>(469) 828-4603<br>(972) 407-1305 |

## NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

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# Jennifer Leister, LPC-S
**17480 Dallas Parkway, Suite 230**
**Dallas, Texas 75287**
**Phone: (469) 828-4603 Email: jennifer@jennifercounseling.com Fax: (972) 407-1305**

## Waiver

The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, in spite of the security measures that I have in place to protect your privacy. By signing below you understand and acknowledge the possible risk and your consent for such practices to be utilized.

- Use of an electronic calendar
- Use of a paper calendar
- Use of a cell phone for communication with you and other professionals
- Use of a laptop computer
- Use of unencrypted email
- Use of computerized billing
- Use of shared office space with the independent practices of other mental health professionals with potential access to, among other things, common storage and file space, mailboxes, voicemail, messages, fax machine and faxes.
- Use of shared administrative staff

_______________________________________________
PRINTED NAME

_______________________________________________
SIGNATURE OF CLIENT OR PARENT/GUARDIAN DATE