Healing heARTS Counseling, LLC
354 NE Greenwood Ave Suite 215
Bend, Oregon 97701
(541) 668-7613

Patient Information & Consent to Treatment

Welcome! We look forward to working with you regarding the concerns that brought you here. Please read the following information concerning our professional services and business policies CAREFULLY, and discuss with your therapist any questions you may have. Your therapist will also go over this consent verbally.

Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with therapy.

Qualifications: Our counselors hold a Master's level degree in counseling, psychology and/or related fields and are licensed by the state of Texas and/or state of Oregon to provide mental health counseling as a Licensed Professional Counselor-Intern or Licensed Professional Counselor. We abide by all requirements and codes of ethics as set forth by the Oregon Board of Licensed Professional Counselors and Therapists and/or the Texas State Board of Examiners of Professional Counselors. Our counselors must complete continuing education units to maintain licensure.

- Heather Wheeler, MS, LPC is licensed by the State of Oregon and State of Texas. She holds a Master of Science degree in Counseling and Development from Texas Woman's University. Her specialties include children and adolescents, trauma/crisis counseling, sexual abuse/assault, childhood abuse, domestic violence, anxiety, depression, and self-harm.

Orientation: Our counselors use a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. These techniques may include person-centered therapy, cognitive-behavioral therapy, art therapy, and sandtray therapy. We believe all people to be unique and have good intentions; however, positive characteristics and healthy lifestyles can become obscured by strong defense mechanisms and painful experiences. Each individual has their own experiences in the world that no one else has had and we value those experiences. We also believe that each individual's culture, race, ethnicity, religion, sexual preference and family structure influence how he/she thinks, feels and responds to events. We accept and value all individuals without judgment, criticism or influence. We do not discriminate based on age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status. Our overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, and relationally.

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, counseling is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals, and working to make changes. We will work to create a safe environment in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. We will also be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Therapy Relationship: While counseling often addresses very personal issues, for your work to be therapeutic, the relationship between you and your counselor must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. **Payment for services rendered is the only compensation that is expected. We will not accept gifts, barter with you, attend social events with you or write references for you. If a counselor or staff member perceives sexual advances from you, we will discontinue our counseling sessions and make a referral to another counselor for you.** Contact with us will be limited to sessions you schedule at our office. **We will not accept friend requests on social networking sites. Additionally, if we see you in public you will not be acknowledged, in order to protect your confidentiality, and will only be acknowledged if you acknowledge us first.** Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled

appointment. Please be advised that we **DO NOT** respond to client emails**. Email is not a secure form of communication and your confidentiality cannot be guaranteed.** Therefore, all scheduling matters or other communication will be done over the phone. All other matters should be discussed during your session time.

Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However we cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, we will anticipate these risks and discuss them with you throughout the course of therapy.

Client Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. We will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with us are crucial to your success in therapy. You have the right to discontinue your professional relationship with us at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations we make. If your refusal compromises our ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), we may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire.

Our services will be rendered in a professional manner consistent with the legal and ethical standards established by the Oregon and Texas state licensing boards for professional counselors. If at any time or for any reason you are dissatisfied with our services, please let us know. If you are still unsatisfied, you may report your complaints to the appropriate state board. You may also examine public records maintained by the board and you may have the board confirm credentials of our counselors.

Oregon Board of Licensed Professional Counselors and Therapists at 3218 Pringle Rd SE, #120, Salem, OR 97302-6312; (503) 378-5499; lcpt.board@state.or.us; www.oregon.gov/OBLPCT
Texas State Board of Examiners of Professional Counselors at P.O. Box 149347 Austin, TX 78714-9347; (512) 834-6677; lpc@dshs.state.tx.us; www.dshs.state.tx.us/counselor/

Emergency Crisis: Please be advised that counselors at Healing Hearts Counseling LLC do NOT provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, call 911 or go to the nearest emergency room for assistance. Additional help numbers include: National Suicide Prevention: 800-273-8255

Referrals: Throughout the course of therapy, we may make recommendations concerning treatment, some of which may involve alternative treatment options we do not provide, e.g. medication evaluations, inpatient or intensive outpatient treatment. If at any time either you or we believe a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment: Fees will be $150.00 for an intake appointment, $120.00 for a 50-minute individual adult session or 45-minute adolescent session, $25.00-$35.00 for a group session, $60.00 for a 30-minute parent consult or child session, and $150.00 for a 90 minute-session. Same day crisis counseling appointments will be billed at the rate of $250.00 for a 50-minute session. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. If you wish to pay by personal check or with cash, you may do so but we still need a credit card number on file to bill for no show or late cancellations. If payment becomes a hardship for you, please discuss this with us so a suitable payment plan can be arranged for you. If payment for services is not rendered within 30 days, you will be required to pay a service charge of $15.00. After 60 days, your payments will be referred to an outside agency and you will be responsible for paying any collection and/or attorney fees or expenses. If a check is returned due to insufficient funds, we will charge a $25 fee upon your next visit or we may charge your credit card on file.

Please initial the following:

_____If you are using insurance to pay for part or all of your session fees, it is YOUR responsibility to verify your benefits, deductibles, copays, etc. If your insurance denies any coverage of services, you will be responsible for paying the full fees. **It is also your responsibility to notify our office if your insurance plan changes. If your plan changes and our office is not notified, you are responsible for any fees that the insurance does not cover.**

Counseling services are provided at rates consistent with those of the area for professional counselors. Services include individual adult and adolescent appointments, group counseling, and parent consults.

Other services for which additional may fees apply include (Insurance will not cover these charges and you are responsible for 100% of the fee):

- Telephone calls over 10 minutes: $50.00
- Clinical consultations with other providers for which you have given your consent: $30.00
- Photocopying and/or mailing of records to you, to another provider, attorneys, insurance companies, etc.: $0.10/page
- Providing documentation/written reports/letters for schools, doctors, insurance companies, etc.: $30.00 (prorated for single page letters)

Court/Legal: *Please initial the following:*

_____ It is in your best interest to know that conducting expert witness/testimonial service is not in our area of expertise or interest. **WE DO NOT** agree to serve as an expert witness or to provide testimonial services for you, your child, or any member of your family, and you agree not to cause our services to be used in this way. If you are seeking counseling for court or court-related purposes or motivation, we will provide you with alternative appropriate referral sources. **For legal proceedings that require our response (**including time spent responding to subpoenas, depositions, case preparations, travel, witness time, any wait time related to a court-related process, etc.), **we bill $300 per hour. You agree to pay this amount, regardless of whose attorney subpoenas our involvement.** Client records will not be released without written consent unless court ordered to do so. Please note a subpoena does not constitute a court order. **You further agree to pay a retainer fee of $1500.00 at the time the subpoena is served, to be applied toward these charges.** If a subpoena is issued for us it will be turned over to an attorney, and we will consult an attorney as necessary at your expense. A bill will be rendered to you for an immediate payment when a subpoena is issued. If you have suspicion that your case will be going to court, or you will need a therapist testimony, please let us know before a counseling relationship is established, and appropriate referral sources will be provided to you. Please note: 24 hour advance notice is required if a cancellation occurs related to the court process, including dismissal of a case. If 24 hour notice is not made a fee of $1500.00 will be billed (5 hours @ $300 per hour).

Cancellation Policy: If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. **Individual or family appointments not kept or cancelled less than 24 hours in advance** will be billed for the time scheduled at the rate of **$50.00** and **group appointments not kept or cancelled less than 24 hours in advance** will be billed for the time scheduled at the rate of **$25.00. Please Note:** Insurance companies WILL NOT cover this fee and your credit card on file will be billed for the full $25.00 or $50.00 fee.

Records and Confidentiality: All records may legally be disposed of five years after the file is closed for an adult and 5 years after a minor child's 18th birthday.

Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your **protected health information,** recorded in your patient file, which will remain confidential and stored securely. The personnel in our office who may need to access your file for administrative purposes are also bound by confidentiality. When disclosure of your records is required by law, you will be notified. Most of these provisions were described to you in the **notice of privacy practices** that you received with the intake packet.

You should be aware of the following **exceptions to confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, we have a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified without your consent.***

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name	**Phone Number**	**Relationship to Patient**
_____	_____	_____
_____	_____	_____

Transfer of Records: If we must discontinue our relationship because of long-term illness, disability, or other presently unforeseen circumstances, we ask you to agree to our transferring your records to Shareen Wornson, MA, LPC-S, 8300 Hwy 380, Suite 200, Crossroads, TX 76227, (469) 235-0359, who will assure confidentiality, preservation, and appropriate access, referrals or other appropriate services.

Vacation, Illness, and Pregnancy Leave Policy: If one of our counselors becomes unavailable to meet with you for a short-term vacation, illness or pregnancy leave, then all crisis calls and crisis appointments will be referred to the counselor on staff at the present time. If that counselor is unavailable, Kimberly Kirk, MA, LPC, NCC will be available for crisis calls during regular business hours only at (972) 916-9396. Crisis calls are limited to 10 minutes and anything over the allotted time will be billed at the scheduled rate. If your concern requires more than 10 minutes to discuss, we ask you to schedule time for an individual session to continue discussing your concerns**. If you are in an immediate crisis or emergency situation, call 911 or go to your nearest emergency room.** Before taking any scheduled leave, your counselor will create a plan for you or your child if you or they need counseling while your counselor is absent. In an unforeseen circumstance, counselors and staff will work with you to create any necessary referrals or plans of action in case of emergency.

By initialing below, I agree that I may receive appointment confirmations from Healing Hearts Counseling LLC in one or more of the following ways.

_____Email _____Phone Calls

I hereby give my consent for psychological treatment from the therapist signed below. I have read this document carefully and understand the information regarding consent and Healing Hearts Counseling LLC services and policies contained herein. I agree to comply with the policies stated.

_____
Client Name (Print)

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services at Healing Hearts Counseling LLC. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Counselors at Healing Hearts Counseling LLC are required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with your therapist.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the

governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

File Security – All files are kept locked in a file cabinet at all times as well as inside a locked file room when counselors and staff are not using the file room. When counselors and staff are not in the office, the office is kept locked, and during the overnight hours, the building is also locked.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____

Client Name (Print)

_____ _____

Client or Parent/Legal Guardian Signature Date

_____ _____

Counselor Signature Date

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CONSENT FOR DISCLOSURE OF INFORMATION

Client Name:_____Parent/Legal Guardian (if applicable): _____

I, _____, hereby provide authorization for Healing Hearts Counseling LLC to provide the following information:

_____ Dates of Service _____ Number of Sessions _____ Multiaxial Diagnosis

_____ Progress Summary _____ Other, specify_____

To the following recipient:

Name:_____

Address:_____

Phone Number:_____

*Please note: If you are using insurance as your payment method, we will need your consent to release your mental health records and information to your insurance company so they can process your claim. If you currently have a CPS case open and would like us to work with your case manager, we will need your consent to release your mental health records and information. If you have more than one entity you would like consent to release information for, please fill out a form for each entity.

**Information released is strictly confidential and is accepted for use solely by and for the parties, as stipulated above for the purpose of providing mental health services.

"I now authorize this release and stipulate this authorization expires, unless otherwise noted, upon termination of treatment."

_____
Client Name (Print)

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date

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Art and Sandtray Therapy Disclosure

What is Art Therapy?

Art therapy is a technique that can be used with individuals of any age and is designed to allow individuals to express their thoughts, behaviors and feelings using art such as drawing, painting, writing, and storytelling. This allows the individual to express themselves in a non-threatening, creative way.

What is Sandtray Therapy?

Sandtray therapy is a technique that can be used with children, adolescents and adults. This type of counseling is designed to allow individuals to express their thoughts, behaviors and feelings using objects in a sandtray. By creating scenes that depict struggles, individuals can process past experiences and future actions in a non-threatening way. Sometimes talk therapy can be a challenge, so sandtray therapy offers a way to visually represent an experience that can be difficult to talk about.

Appointments and Records

Art and Sandtray therapy sessions will be held weekly for a period of 50 minutes for an adult client, and 30-45 minutes depending on the age of a child client. Parent consults will be scheduled once a month and can be scheduled prior to your child's normally scheduled session or at a different time during the week. Parent consults will be scheduled for 30 minute sessions and fees are located on the **Patient Information & Consent to Treatment** Form. If you feel you need more time for your consult, please let us know and we can discuss your needs.

Photos will be taken of artwork and sandtray scene a client creates for the purpose of record keeping, and will be placed in the client's file.

If you have children attending sessions:

What should I talk about with my child about their therapy sessions?

Prior to the first session, we recommend talking with your child about them meeting with someone with whom they can talk freely with. You might tell them that they will be allowed to create art or scenes in a sandtray in order to help communicate any issues that may be difficult to talk about. **We also recommend not pushing or persuading your child to discuss what happens in each session. Children over time will come to tell their parents about what they are doing once they feel safe and have a sense of empowerment. If a child encourages discussion about sessions, then feel free to discuss them but only as far as the child is willing to go.**

What will you tell me about my child's sessions?

We choose to maintain complete confidentiality with each child. However, there are several reasons we would break this confidentiality. These reasons include if your child discloses that he/she is being physically, emotionally or sexually abused, if your child discloses potential harm to themselves or others, and if we are ordered by a court to testify about our sessions. We will also discuss general themes of sessions with you but will not tell you exactly what your child has said. We choose not to discuss specifics in order to make the child feel that they are in a safe environment where they can talk about anything they wish to discuss without feeling like they will be judged or that someone will tell other people. A safe environment is important for healing from difficult experiences.

By signing this form, you understand the above information and agree to have photographs taken of artwork and sandtray scenes to be kept for record purposes.

_____
Client Name (Print)

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date

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Credit/Debit Card Payment Authorization Form

Sign and complete this form to authorize Healing Hearts Counseling LLC to make a charge/debit to your credit/debit card listed below. If Healing Hearts Counseling LLC is unable to process my payment I will be responsible for an alternate payment arrangement and any resulting processing fees.

By signing this form, you give Healing Hearts Counseling LLC permission to debit your account for the amount indicated on or after the indicated date.

This form gives permission to charge for no-show appointments or late cancellations. This form gives permission to charge for a remaining balance that insurance has denied unless you set up an alternate payment plan within 30 days of my first attempt to contact you.

Please complete the information below:

I,_____, authorize Healing Hearts Counseling LLC to charge my credit/debit card account for the appropriate session fees which may include but are not limited to: copays, coinsurance, self-pay fees, late cancellation fees, and no-show fees.

By my initials below, I agree that Healing Hearts Counseling LLC may charge my credit/debit card for ongoing sessions, as needed.
Yes_____No_____

This authorization allows for charges for no-show appointments and late cancellations (less than 24 hour notice) which will be charged a flat fee of $50.00, as insurance WILL NOT cover missed appointments.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover

Cardholder's Name:_____

Billing Address:_____

Driver's License #_____State Issued:_____Expiration Date:_____

Card Number:_____

CVV:_____Expiration Date:_____

Signature_____ Date_____

*I authorize the above named business to charge the credit/debit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit/debit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

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Acknowledgement of Notice of Privacy Practices
(For Client File)

"I hereby acknowledge that I have received a copy of Healing Hearts Counseling LLC **Notice of Privacy Practices,** which was discussed verbally with me by my counselor**.** I understand that if I have any questions or complaints regarding my privacy rights, I may contact Healing Hearts. I further understand that Healing Hearts Counseling LLC will offer updates to this Notice should it be amended, modified or changed in any way."

_____
Client Name (Print)

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Client or Parent/Legal Guardian Signature Date

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Counselor Signature Date

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Acknowledgement of Notice of Privacy Practices
(For Client to Keep)

"I hereby acknowledge that I have received a copy of Healing Hearts Counseling LLC **Notice of Privacy Practices,** which was discussed verbally with me by my counselor**.** I understand that if I have any questions or complaints regarding my privacy rights, I may contact Healing Hearts. I further understand that Healing Hearts Counseling LLC will offer updates to this Notice should it be amended, modified or changed in any way."

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Client Name (Print)

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Client or Parent/Legal Guardian Signature Date

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Counselor Signature Date