



# HKA Counseling

HKA Counseling, PLLC

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## **PRACTICE POLICIES**

### **APPOINTMENTS AND CANCELLATIONS:**

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 55 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 55-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A \$10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

### **FEES:**

The fee for the initial appointment, known as the Psychiatric Diagnostic Evaluation, is \$115. After the initial appointment, my fee for an individual, couples, or family session is \$100. Group therapy, when available, is \$40 per 45-50 minute group session. Payment is due at the time services are provided.

Fees associated with work provided outside of your therapy session include telephone consultations that exceed 10 minutes. These are billed at a rate of \$2 per minute. Reports and letters generated at your request, and exceeding 10 minutes of work are \$60 per 30 minutes.

### **INSURANCE:**

I am in network with select insurance providers and have accepted a contracted rate to provide you with psychological services. Should you wish to utilize your insurance benefits to assist with

covering the costs of your therapy, I encourage you to contact member services and verify your Outpatient Behavioral Health Eligibility and Benefits. I can assist with this process, but cannot guarantee coverage and/or reimbursement. If you are not covered for services with me or if your claim is denied, you will be held financially responsible for my full fee. As a courtesy and upon request, I will provide you with a statement, referred to as a Super Bill, which is necessary to file an insurance claim if I am out-of-network. It is your responsibility to file and discuss any issues concerning your reimbursement with your insurance company.

#### **TELEHEALTH & INSURANCE:**

If you are interested in utilizing your insurance benefits to assist with covering the costs of your Telehealth services, I encourage you to contact member services and verify if your specific plan accepts telehealth (live video and audio sessions) as an active benefit. If it does not, we can still do telehealth, but our sessions will not be billed through insurance and will be billed directly to you at my contracted rate, per session. If you do have telehealth coverage as part of your plan, please provide me with the reference number and representative you spoke with before we start telehealth services. If once initiated, claims submitted result in denial and are not paid out accordingly, you will assume financial responsibility for the unmet balance of my contracted rate.

#### **TELEPHONE ACCESSIBILITY:**

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 48 hours. If a true emergency situation arises, please call 911 or any local emergency room.

#### **SOCIAL MEDIA AND TELECOMMUNICATION:**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

#### **ELECTRONIC COMMUNICATION:**

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine. If we chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

**COURT:**

I do not testify in court as an expert witness. If you are seeing me for marital or relationship therapy I will not be available for court testimony for either partner. In rare and unusual situations where I might be required to testify in civil court, I will require a fee of \$150.00 per hour, including travel and wait time. Consultation with attorneys or litigants (in person or via

phone), report writing, review of records, and any other service associated with a legal dispute will be billed at a rate of \$150 per hour (prorated). If I am subpoenaed or otherwise committed to appear in a legal case involving you, and the appearance is cancelled with less than 48 hours' notice, you will be billed \$1000 to offset the cost of a lost day of my work. These rates are enforced whether you, or another litigant in a case involving you, have compelled me to become involved. Failure to keep your account current may result in legal action or collection agency intervention.

**MINORS:**

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

**TERMINATION:**

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

**TO BE KEPT BY CLIENT**

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I have received a copy of this document.

I hereby acknowledge that Adriana Gonzalez, MA, LPC has presented me (us) with the Practice Policies.

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Patient Printed Name	Patient Signature	Date
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Patient Printed Name	Patient Signature	Date
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Guardian Printed Name	Guardian Signature	Date
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**TO BE KEPT BY OFFICE**