

Heart Change Counseling

Welcome to **Heart Change Counseling!** My desire and prayer is that your life will be forever changed by your experience here as God's Holy Spirit works through you and me and changes hearts through the truth and power of His Word.

As you begin your counseling experience here at **Heart Change Counseling**, I want to make you aware of some things that are essential if your counseling experience is to be effective. They are as follows:

- The counseling you will receive here is drawn from God's Word.
- Biblical counseling is always "heart focused". I will explain this further as we go along. But the truth is that unless a person's heart changes, there can never be permanent change or healing in your life.
- Heart change is not just about gaining head knowledge, but also includes accurately applying God's Word to one's life (Matthew 7).

In truth and love, I, as your counselor will endeavor to help you choose to change your heart so that you may find healing and to possess the abundant life that Christ came to give you (John 10:10). If you are ready to examine your own heart and allow the Lord to convict you through His Word and the counseling process, then you can experience healing and enjoy the Fruit of the Spirit (Gal. 5:22).

I am excited to be with you on this journey, and I pray that your heart is ready for God's healing touch on your life, your marriage and your family!

Dwayne Collins, MA, LPC
Heart Change Counseling
www.hcmin.com

Fee Schedule

WHAT ARE YOUR FEES?

Perhaps the very first question most people ask is “What will counseling sessions cost me?” This is a legitimate question. Any organization, whether profit or non-profit, has expenses. When God called us to counseling, He called us to a ministry. And, although the number one concern is the ministry, we still have expenses. We are not supported by any non-profit organizations, groups, or churches and therefore must charge a fee.

Southlake Office:

The normal fee for each session is \$100. We are able to provide a limited number of professional discount fees on an as needed basis. This discounted fee will range from \$75-\$95. If the normal fee of \$100 will create a hardship, **it is the responsibility of the client to ask for the professional discount.**

Lewisville Office:

The normal fee for each session is \$75. We are able to provide a limited number of professional discount fees on an as needed basis. This discounted fee will range from \$50-\$70. If the normal fee of \$75 will create a hardship, **it is the responsibility of the client to ask for the professional discount.**

Please note that payments are due at time of service. Acceptable forms of payment are cash, check, Master Card, Visa, or Discover.

DO YOU ACCEPT INSURANCE?

Heart Change counseling does not accept insurance. However, if your insurance coverage has provision for “Out-of-Network” benefits, we will provide a receipt that is acceptable to your insurance provider if you wish to file a claim. It is the responsibility of the client to know what their insurance benefits are and to file their claims.

Heart Change Counseling

Dwayne Collins, MA, LPC

250 W. Southlake Blvd., Ste. 202

Southlake, TX 76092



250 N. Mill St., Ste. 6

Lewisville, TX 75057

NOTICE OF PRIVACY PRACTICES

(Client's Copy)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

MY LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2006, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before I make a significant change in my privacy practices, I will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or other practitioner.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within the counseling practice of Heart Change Counseling and Dwayne Collins, MA, LPC, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of the counseling practice of Heart Change Counseling and Dwayne Collins, MA, LPC, such as releasing, transferring, or providing access to information about you to other parties.

2. I may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person's involvement with your care or payment related to your health care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your counseling notes. *"Counseling notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Texas Department of Protective and Regulatory Services.

Health Oversight: If a complaint is filed against me with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, I will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

For more information about my privacy policy or if you have questions or concerns, please contact me. If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may complain to me using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with that address to file your complaint upon request.

Contact: Dwayne Collins, MA, LPC

Telephone: 469-261-5123

Address: 250 W. Southlake Blvd., Ste. 202
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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____

Date _____

For office use only

- I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:
- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented me from obtaining acknowledgement
- Other (Specify below)

Heart Change Counseling
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250 N. Mill St., Ste. 6, Lewisville, TX 75057
469-261-5123
dwayne@hcmn.com - www.hcmn.com

Client Information

Date: _____

Client's Name: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Email _____

Phone: (____) _____ (____) _____ (____) _____
Home Work Cell

Spouse /Guardian/Parent Information

Name: _____
First Middle Initial Last

Address (if different from client): _____

Social Security #: _____ Date of Birth: _____ Email _____

Phone: (____) _____ (____) _____ (____) _____
Home Work Cell

Other Information

Dependents: _____
Name Relation DOB

Name Relation DOB

Name Relation DOB

Church Affiliation: _____ Referred by: _____

Credit Card Consent Form

I give my expressed permission for any session fees, missed, or late cancelled appointments incurred by myself or any of the following person(s) _____ to be charged to the following credit card for sessions with Dwayne Collins, MA, LPC.

Name: _____ (As it appears on card) Card Type: _____

Number: _____ V Code: _____

Expiration Date: _____

Signature of Credit Card Holder: _____

Dwayne Collins, MA, LPC

It is my deepest desire to help you with whatever problem has brought you to me through the truth and power of God's Word. He is the Creator and Designer of all things, and there is no human situation for which He does not have a solution. Together we will work towards that solution based on the truth that is provided to us in Scripture.

Confidentiality: Everything said here is protected by the confidentiality statutes of the State of Texas. That means Dwayne Collins, MA, LPC will in no way disclose any information without your written consent except in the following situations: (a) If you threaten bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of the physical or sexual abuse of a minor child by an adult or of an elder (over 65) by an adult, I am required by law to inform the appropriate welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or am ordered to testify regarding those records.

Appointments: Counseling sessions are 45-50 minutes. For counseling to be effective several things are required: commitment to the process through faithfully attending appointments; completing "homework assignments" between sessions; establishing clearly defined goals (I will help do this in the first session); and a willingness to accept the truth, as found in God's Word, and integrate it into your life. I require that 24 hours notice be given if canceling an appointment becomes necessary. A **credit card on file** is required and **you will be charged** for the session if less than 24 hours notice is given; emergency situations may be discussed with your counselor. **Initial:** _____

Financial Policy: The standard fee for services provided by Dwayne Collins, MA, LPC in the Southlake office is \$100 per session. A limited number of Professional Discount Fees can be provided ranging from \$75-\$95 on an as needed basis. The standard fee for services provided by Dwayne Collins, MA, LPC in the Lewisville office is \$75 per session. A limited number of Professional Discount Fees can be provided ranging from \$50-\$70 on an as needed basis. Payment is due when services are rendered, at the end of each session. Dwayne Collins, MA, LPC does not participate in managed care agreements with insurance companies. Dwayne Collins, MA, LPC will provide a receipt to the client to enable the client to file for insurance benefits with their insurance provider. Please let me know if you have any questions. **Initial:** _____

Legal: Charges for services such as consultations to attorneys, depositions, to present any or all records pertaining to the counseling relationship to a court official or testify in court proceedings are billed at **\$200.00 per hour with a minimum of 8 hours, for a total of \$1600.00**. In the event that any of these situations occur, **you, the client agree to pay me for my services**, in addition to travel, preparation, and necessary expenditures (copies, parking, meals, etc.) at the rate of \$200.00 per hour, rounded to the nearest quarter hour. You, the client, also agree **to pay the \$1600.00 retainer 2 weeks prior to the appearance, presentation of records, or testimony requested**. I ask that you only request a court appearance in extreme cases. This action will likely result in the need to terminate therapy and I will need to refer you to another therapist. **Initial:** _____

If client is under 18, I _____ (please print), have legal custody and give my consent for counseling of the above named minor.

_____ Signature of Parent or Guardian

All members of your family who are involved in counseling need to sign below, indicating understanding of these policies and procedures.

ACKNOWLEDGED:

Date: _____ Client's Signatures: _____

Counselor: Dwayne Collins, MA, LPC