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Licensed Psychologist*

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## **PROFESSIONAL DISCLOSURE STATEMENT AND NOTICE OF PRIVACY PRACTICES**

Welcome to my practice. I am glad you are here and am committed to providing you with quality care. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you may have so we can discuss them.

### **COUNSELING RELATIONSHIP**

The counseling relationship between client and psychologist is one of mutual responsibility. Counseling is a process in which both work together to define/explore the client's feelings and goals and work toward achieving such therapy goals. However, the ultimate responsibility is with you, the client, to decide what the therapy goals will be. I will assist you in making sure therapy goals are challenging but realistic, then we will work within the framework of such. While professionalism will be maintained at all times, the client/psychologist relationship is also warm and personable, within the context of mutual confidence, respect and trust.

### **COUNSELING PROCESS**

The counseling process involves four stages. **EXPLORATION** stage is for the purpose of defining the problem. The client and psychologist work together to define realistic, measurable, and mutually agreeable psychotherapy goals, in the **GOAL SETTING** stage. In the **WORKING** stage, the psychologist and client work together to achieve the goals established in the preceding stage. **CONCLUSION** and **TERMINATION** stages are when the defined goals have been satisfactorily achieved and/or the client is able to function independently in the goal areas. The client will be helped to formulate plans for personal maintenance and schedule a check up point from one to six months. Each of these stages may need to be revisited from time to time as the process and issues unfold. After some work has been done in the working stage, for instance, the client may decide to revise a goal and work in a new vein. Then, it may be necessary to do more exploration in order to discover pertinent underlying feelings and issues, and establish new therapy objectives.

## **RISKS AND BENEFITS OF THERAPY**

While benefits of therapy may be tremendous, there are some risks of which one should be aware. Counseling opens up levels of awareness which could cause some pain and anxiety. Personal changes often mean changes in relationships. Clients should be aware that those to whom they closely relate, sometimes do not respond positively to therapy related changes, and it may be necessary to deal with relational adjustments, should they unfold. Therapy requires much effort, struggle and sometimes pain but marks a season of growth, progress and healing in a person, couple or family's lifestyle. It must be left to the client to decide whether the gain is worth the effort, change or pain.

## **CONFIDENTIALITY ISSUES**

Your communications in therapy are completely confidential, as required by professional standards and HIPAA. However, there are some exceptions to make note of: communications to a qualified law/medical personnel if a client threatens serious, mental/emotional/physical harm to self; if a client reports abusing an elderly, handicapped or disabled person or child/teen; if a psychological issue related to a child's therapy arises in a custody battle; if a client uses therapy to evade arrest for a crime; if a client discloses therapy information related to the client's condition as a party of a claim or defense regarding such; in a court-ordered examination; to a governmental agency or official legislative inquiry as required by law; to insurance personnel as necessary to obtain more sessions or process of any insurance/EAP/HMO/PPO claims for psychotherapy services rendered; in a civil or criminal action as allowed by law or ordered by a judge; when proceedings are brought by a client against a therapist; when a client waives confidentiality of therapy records in writing, when a professional collection agency is used in collecting fees for services rendered; and/or to a client's representative if the client is deceased.

Select information may also be shared with administrative staff affiliated with me in order to verify benefit information, schedule sessions, take messages, process requests for more sessions, quality assurance and/or to obtain payment for services rendered. All mental health staff are bound by the confidentiality rules. All practitioners are independent providers and share only office space expenses, so this would only affect administrative staff. The staff has been given training regarding privacy issues and will not disclose any information outside the psychology practice without permission of the psychologist/client. A contract has been made with my answering services in which they commit to maintain confidentiality of client information, except as specifically allowed by the contract. If you wish, I can provide you with the names of these organizations.

In order to process claims, insurance companies must have such information as diagnosis, dates of service, fees charged and in some cases I am required to provide additional clinical information such as treatment plans or summaries, or sometimes (rarely) copies of client's case file. In such situations I will make every effort to release only minimum information necessary for the purpose requested. This information will become a part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information very confidential, I have no control over what they do once it is in their hands. Some insurances may share information with a national computer data bank. I will inform you of any confidential therapy information sent, upon request. By signing this agreement, you agree that I can provide requested information to your insurance carrier.

### **CLIENT RIGHTS**

The client has the right to: Request an explanation of the rationale of my treatment or intervention and/or to refuse any treatment; to know the psychologist's views and values regarding relevant life issues and/or general treatment paradigm; to end therapy or seek referral at any time during therapy; to know the psychologist's credentials and experience level; to request significant others to be present in the therapy session; to rescind authorization to release confidential therapy information; to know the length of sessions and/or general treatment protocol for a particular problem; to be informed of fees involved for therapy or testing.

HIPAA federal privacy rights include: confidential communication; to request restriction on use and disclosure of confidential treatment information (however I am not required to necessarily agree to such), as well as right to request alternative means and/or location for receipt of confidential communication; to review or obtain a copy of mental health records via letter request; to amend or correct mental health information via letter request, using HIPAA procedure; to be informed of how and to whom treatment information is being disclosed; to obtain a copy of this notice of general privacy policy; and/or to ask questions and/or express feedback/concerns regarding psychology privacy; information practices to Dr. Sarah Randel. Therapy services will not be compromised when a client expresses concerns regarding privacy practices. Privacy policies may be amended or modified as federal law mandates and I will provide you with any notice of such at the time of your appointment. A current copy of privacy practices will be made available in the office.

### **OFFICE PROCEDURES**

Sessions last 45-50 minutes and the fee is \$150.00 per session. If you are unable to keep an appointment, please **GIVE 24 HOUR COURTESY NOTICE. APPOINTMENTS CANCELLED LATER THAN THIS WILL BE CHARGED THE REGULAR OFFICE VISIT FEE.** Longer sessions, phone consultation, letter writing and/or court preparation, consultation or travel will be billed according to the hourly rate.

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### **PATIENT PAYMENTS**

Co-pays or coinsurance is to be paid for at the time of service. Currently we only accept cash or personal checks. Payment of fees is due at time of therapy services.

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### **INSURANCE BENEFITS & VERIFICATION**

Please be advised that verification of benefits is not a guarantee of claim payment and a final coverage determination cannot be made until your insurance company receives a claim of examination. This disclaimer is provided to advise you that if your insurance company deems your claim not medically necessary or does not pay the entire amount of the claim, you will be solely responsible for payment of any remaining balance on the claim identified as “patient responsibility” or “patient portion”. We estimate the patient’s responsibility to the best of our ability. Estimated charges could differ based upon the actual visit or tests administered by Dr. Randel. In the event that the estimated charges differ from the actual charges, a statement for those charges will be billed to you.

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### **MISSED APPOINTMENTS & LATE CANCELLATIONS**

As a courtesy, we will make a reminder call to you the business day prior to your appointment. Please be advised that this is only a courtesy call and is not necessarily within 24 hours of your appointment. You are responsible for any necessary appointment cancellations within 24 hours of the appointment, regardless of whether the courtesy call was received by you or not. Failure to do so will **result in a late cancellation fee. This applies to a missed appointment as well.** This fee is not billable or paid by insurance. It is the responsibility of the patient and must be paid for at or before your next appointment. If 3 visits are cancelled within a 5 week period, Dr. Randel reserves the right to discontinue therapy, as therapy requires an ongoing, consistent commitment to accomplish any therapy goals. Moreover, we are mindful of accommodating those on a long waiting list.

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## **LEGAL SERVICES**

Please be advised that should any portion of yours or your family's therapy or Dr. Randel's services entails or results in a legal matter, such as consultations, preparation of reports, travel time to court or court testimony, etc., legal services are billed at an hourly rate of \$225.00 which the patient or guarantor on the account is solely responsible. A deposit will be required. Reports and/or letters will not be released to the person(s) it is intended for, or addressed to, prior to the charges for such services being paid in full. If the charges are being split between two parents for instance (assuming this is directly related to a child of divorced parents), then both parties must have paid their portion in full prior to Dr. Randel releasing the report/letter. Phone consultations must be paid for in advance and are billed at a standard session rate.

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## **TESTING & NON-LEGAL REPORTS OR LETTERS**

If Dr. Randel feels it necessary to administer tests for you or a child for diagnostic purposes, often the testing is covered by insurance, but not always, in which case the guarantor on the account will be responsible financially. Again, the results will not be discussed or released until the charges for such tests are paid in full. If insurance does not cover testing, these charges will be billed at a rate of \$150 at 45 minute intervals (same amount of time for each therapy session). The number of testing sessions will be determined by the tests which are to be administered, usually 2-8 sessions total. Dr. Randel will discuss this with you prior to any tests being administered and the charges associated with the services.

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## **EMERGENCY PROCEDURE**

If you have an emergency and cannot reach Dr. Randel, please call **911** and/or Tarrant County or Dallas County Crisis Intervention and/or go to the nearest hospital immediately and get help from the psychiatrist on duty!

## **AUTHORIZATION FOR RELEASE OF RECORDS**

Your signature indicates you have read this document, understand it, and consent to the provisions therein. Your consent allows Dr. Randel to confer with and or supply a treatment plan (including diagnosis and dates of services) and/or other requested information to your insurance company/HMO/PPO/EAP as necessary to obtain treatment session certification, verification, and/or remittance. Your signature also indicates you have received a copy of this HIPAA notice form.

If your minor child/children is/are in therapy with Dr. Randel, your signature indicates you have conservatorship of your child/children and have the legal right to determine their treatment and release of their records. You also accept financial responsibility for their psychotherapy services.

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Client/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date