JoDana M. Varilek
LMSW, LCSW, LSSW, LCWS
469-414-5800
jodie@jodanavarilek.com • www.jodanavarilek.com

Informed Consent for Psychotherapy

General Information:

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing this document.

The Therapeutic Process:

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you, point out repeating patterns, observations as well as to help you clarify goals that you would like to achieve as a part of our time together.

Confidentiality:

Confidentiality is of the utmost importance.

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons listed on your emergency contact. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts herself/himself in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Child Counseling/Play Therapy Logistics:

For play therapy, sometimes it may be necessary to end the session early depending upon the following circumstances: the condition or cleanliness of the playroom, the child's ability to leave when the session is over, a situation where play therapy could no longer continue (e.g., child gets sick, child breaks several toys, child chooses to leave and not return, etc.), and the need for a parent consultation. Because the session may need to end early at times, please be sure to remain in the waiting room for most of the session. If you leave the waiting area, please advise the administrator that you are leaving and provide a contact number.

Children in the playroom are not asked to clean the room following the session. The reason for this is as follows: If play is a child's language and toys are the child's words; having a child clean up the playroom following the session would be analogous to asking the child to clean up his/her emotional world. It would be similar to having an adult take back everything he/ she said at the end of the counseling session. This is a unique stipulation to play therapy—please know I am not advocating this action for other circumstances—only play therapy.

When the child greets you in the waiting room following the counseling session, it is best not to ask several questions, such as "Did you have fun?"- While playing is a natural, pleasurable activity for the child, children in play therapy are involved in playing out problems and emotional struggle and, therefore, at times "playing" may not be so enjoyable. Furthermore, when asked what the child did in play therapy, the child will typically respond, "I played." This would be similar to asking an adult in counseling what he or she did in the session, "We talked."

Before your child attends play therapy, please take him/her to the bathroom. Play therapy can often be very emotionally freeing, causing the child sometimes to have to use the bathroom during therapy. It is helpful if the child goes to the restroom before the session begins. Also, if your child is coming from school and is hungry, please give him/her a snack before therapy starts. Only in rare circumstances will food be provided for a child in play therapy. In such a situation, this will be discussed with the caregiver and added to the treatment plan. Please know that the playroom has a variety of media that can be messy (e.g., easel paints, water-color paints, Play-Doh, clay, water, sand, etc.). Please dress your child in clothes that can tolerate mess or possible stains should the child spill paint on him/her. Also, if your child is allergic to any substance that falls into this realm, it is your responsibility to let the play therapist know so that appropriate modifications can be made for your child.

The play therapist will meet with you in person, by phone, or through e-mail to give feedback on your child every third session. While the feedback will discuss overall play themes for your child, discussion on several specific play behaviors will not be discussed to protect the child's confidentiality. However, most certainly at times, it will be necessary to discuss specific play behaviors and what this may mean for your child.

Cancellations due to illness:

If your child is contagiously ill and/or has had a fever in the past 48-hour period prior to their scheduled appointment, please do not bring them to counseling. Instead,

please notify me via email and/or phone as soon as possible. If your child has had lice or nits prior to their appointment, please notify me as soon as possible; we require that they be cleared by their school nurse or general physician before coming to the office.

Fees:

In return for a fee of $175 per 45-minute session, I agree to provide counseling services for you. My starting fee is $175 per 45 minutes, but we do offer a sliding fee scale based on financial ability for those who qualify.

I am in network with most insurance companies. I use Headway to submit claims on your behalf to insurance companies. In order to bill your insurance company for therapeutic services I would first need to establish an account for you where you would input your insurance information. It takes 1-3 days for Headway to verify your insurance benefits so that you are aware of the cost per session prior to your first appointment. Upon completion of your session you will receive an email of your receipt of payment for private pay clients. For clients that bill through Headway you will also receive notification. The fee for each session will be due prior to the commencement of each session. No refunds are given.

No-show and late cancel appointments will incur the full session fee. Phone consultations will incur the following fees: 10 minutes or less = no charge; 11-20 minutes = $58 (one third of session rate); 21-30 minutes = $87.50 (one half of session rate); 31-45 minutes = $175 (full session rate). There may be fees for the use of certain psychological assessments, the fees for which will be discussed prior to their use.

Right to withdraw from treatment:

If a conflict arises for the client or the therapist, either has the right to withdraw from the treatment process. If the therapist feels the need to withdraw from providing treatment, he/she will so inform the client and provide appropriate referrals.

Record storage/interruptions in service:

If an unforeseen event occurs which renders your therapist unable to continue to provide service (illness, death, retirement, etc.) I will provide you with information on obtaining your records should you need a referral. In the event of a sudden illness,

etc., you will be notified of the crisis situation, referred to a therapist to provide services in the interim until your therapist is able to return to work.

In the unlikely event that your therapist in her clinical judgment believes you to be dangerous to yourself or to someone else, by signing the consent you authorize her to contact either the 3 persons listed as your emergency contacts, or someone else to provide assistance through this crisis situation.

In an emergency situation, the office phones are answered after hours by an answering service and you will be forwarded to your therapist's cell phone. Calls are returned as soon as possible. However, in the event that your therapist is unavailable, you may call the Suicide and Crisis Center/hotline at any time at 214-828-1000. Non-emergency phone calls will be returned the following business day.

Court:
I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree not to cause me to be used in this way.

Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceedings, you agree to pay to $400 for every hour of my time involved including case preparation, travel and witness time. You further agree to pay a non-refundable retainer fee of $1,500 at the time a subpoena is served to be applied toward these charges. A bill will be rendered to you for immediate payment when a subpoena issued. The records can only be released to court if a release of information form is signed by all parties involved in treatment. Upon obtaining a release of information authorization, you may acquire a copy of the records. Record copying fees begin at $35.00.

Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

If you have read and agree with all items mentioned above, please sign your name below. I strongly urge you to obtain a copy of the consent for your records. If you have questions about any of the information on this form, or you have any complaints about the procedure, please discuss them with your therapist.

I am looking forward to working with you.

_____

Client's Name Client's Signature Date

_____

Signature of The Guardian Date

ANY PROBLEMS REGARDING ETHICAL QUESTIONS AND/OR CONCERNS MAY BE DIRECTED TO THE TX STATE BOARD OF SOCIAL WORKER EXAMINERS (8407 WALL ST. AUSTIN, TX 78754) OR CALL 512-719-3521 TO ADDRESS YOUR CONCERNS OR QUESTIONS.

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Telehealth Consent Form for Psychotherapy

I, _____ hereby consent to engage in Telehealth with JoDana M. Varilek, LMSW, LCSW, LSSW, LCWS.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist

believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them, and I have been provided with this information in the Fees and Billing Services Form.

I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered prior to the start of services.

I am looking forward to working with you.

_____

Client's Name Client's Signature Date

_____

Signature of The Guardian Date

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Child & Adolescent Intake (Parent's Form)

Welcome! Thank you for making your first appointment. Taking the first step shows courage and bravery. I would appreciate it if you would please review and sign this paperwork, where indicated. Please return all signed documents, in addition to a copy of your driver's license and current insurance card, prior to your scheduled appointment. I am looking forward to working with you.

JoDana M. Varilek, LMSW, LCSW, LSSW, LCWS

Attention Child's Legal Guardian Managing Conservator: if the child is not living with both natural parents, both adoptive parents, or the only living parent, please be advised that **this practice requires a photocopy of the most recent legal document stating custody arrangements. Services will NOT be rendered if no copy is produced.**

Parent/Legal Guardian's Name _____
Last First Middle

Child's Information

Child's Name:

_____
Last First Middle

Address: _____
Street

_____
City State Zip Code

Gender	Age:	Date of Birth:

Race:	☐ African American ☐ Asian ☐ Latino/Hispanic	☐ Native American ☐ Multi-racial	☐ Other ☐ White/Caucasian
Sexual Orientation:	☐ Bi-Sexual	☐ Heterosexual	☐ Homosexual ☐ Other

Religion / Spirituality	
Social Security #	
Year in School:	
School:	
Teacher's Name:	
Current Grades:	

Is your child in Special Education?	☐ Yes	☐ No
Does your child have friends?	☐ Yes	☐ No
Has your child met with the school counselor?	☐ Yes	☐ No
Any concerns with School academics, discipline, social problems?	☐ Yes	☐ No
If yes, please explain:		
Have they experienced being bullied?	☐ Yes	☐ No
If yes, please explain:		
Has your child been assessed though the school district for special education services?	☐ Yes	☐ No
If yes, please explain:		

Please bring copies for JoDana Varilek to review prior to your intake appointment

How were you referred to me?	

Emergency Contact

Name	
Cell Phone	
Home Phone	
Work Phone	

Parents / Guardian Information:

Mother

Name					
SSN:		Age:	Date of Birth:		
Race:	☐ African American ☐ Asian ☐ Latino/Hispanic	☐ Native American ☐ Multi-racial	☐ Other ☐ White/Caucasian		
Street Address		City	State	Zip	
Employer:		Occupation:			
Work Phone:		May we contact you at work?	☐ Yes	☐ No	
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widow	

Is there a past or present history of mental health related issues?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present history of emotional/mental/behavioral health/and/or conduct issues?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present history of suicide attempt(s) that you have experienced?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present history of inpatient psychiatric care that you have experienced? ?	☐ Yes	☐ No
If yes, please explain		

Is there a past or present history of addiction?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present situation of sexual abuse that you have experienced?	☐ Yes	☐ No
If yes, please explain		
Is there a history of physical abuse that you have experienced? History of family violence?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present situation of emotional abuse that you have experienced?	☐ Yes	☐ No
If yes, please explain		

Father

Name				
SSN:		Age:	Date of Birth:	
Race:	☐ African American ☐ Asian ☐ Latino/Hispanic	☐ Native American ☐ Multi-racial	☐ Other ☐ White/Caucasian	
Street Address		City	State	Zip
Employer:		Occupation:		
Work Phone:		May we contact you at work?	☐ Yes	☐ No
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widow

Is there a past or present history of mental health related issues?	☐ Yes	☐ No
If yes, please explain		

Is there a past or present history of emotional/mental/behavioral health and/or conduct issues?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present history of suicide attempt(s) that you have experienced?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present history of inpatient psychiatric care that you have experienced?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present situation of drug or alcohol abuse that you have experienced?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present situation of sexual abuse that you have experienced??	☐ Yes	☐ No
If yes, please explain		
Is there a history of physical abuse that you have experienced? History of family violence?	☐ Yes	☐ No
If yes, please explain		
Is there a past or present situation of emotional abuse that you have experienced??	☐ Yes	☐ No
If yes, please explain		

If the child's biological parents are divorced, how long was the marriage?			Years	Months
If divorced, how long?			Years	Months
How old was the child when the divorce happened?				
Is the child adopted?	☐Yes ☐No			
Custody arrangement?	☐ Joint	☐ Primary	☐ Temporary	
Who has custody?	☐ Mother	☐ Father	☐ Grandparents	☐ Other
Is there currently a custody dispute	☐Yes ☐No			
If divorced, mark which of the following describes your relationship with your ex-spouse/partner:				
☐ Hostile	☐ Frustrating	☐ Acceptable	☐ Friendly	☐ Great
Are there any Co-Parenting Issues?	☐ Yes	☐ No		
If so, what are they?				

I understand that I must provide JoDana M. Varilek with the most current court papers regarding custody arrangement

Date Printed Name Signature

Household Income: (We need this information whether or not you use insurance or pay a subsidized fee.)

Care and Counseling is a non-profit organization and is able to provide subsidized counseling due to the contributions of our many funders. In order to secure funding, it is often necessary to provide aggregate household income data for our client base, which illustrates our financial need. This figure is to include all sources of income -- i.e. salary, child support, maintenance, investment income, housing allowances. **Please check the appropriate range for your gross family income** and the number of members living in or financially dependent on your household. Information provided to funders is only given in aggregate form and individual client information is not released.

$0 - 10,000	_____	$50,001 - 60,000	_____	$100,001 - 110,000	_____	$150,001 - 200,000	_____
$10,001 - 20,000	_____	$60,001 - 70,000	_____	$110,001 - 120,000	_____	$200,001 - 300,000	_____
$20,001 - 30,000	_____	$70,001 - 80,000	_____	$120,001 - 130,000	_____	$300,001 - 400,000	_____
$30,001 - 40,000	_____	$80,001 - 90,000	_____	$130,001 - 140,000	_____	$400,001 - Higher	_____
$40,001 - 50,000	_____	$90,001 - 100,000	_____	$140,001 - 150,000	_____	**Number in household**:	_____

General Health Information (For your child and/or adolescent)

Family/General Doctor:		Phone:
Gynecologist:		Phone:

Current / Past Medications

Are you currently taking any medication at this time?	☐ Yes	☐ No
If yes, please share name, dosage, frequency and purpose		

Name	Dosage	Frequency	Purpose

Current Health

How would you rate your child's current physical health?			
☐ Excellent	☐ Good	☐ Fair	☐ Poor
Please list any specific health problems you are currently experiencing			
Does your child/adolescent have trouble sleeping?		☐ Yes	☐ No
If yes, please explain:			
How many times a week does your child exercise for 30 minutes or more?			
☐ None	☐ 1 – 2	☐ 3 - 4	☐ 5+
Is your child currently under treatment by a physician for any medical condition?		☐ Yes	☐ No

Developmental History

Please indicate if any of the below events were "normal" or "abnormal." Please describe any significant event.

Physical:

☐ *normal*	Pregnancy and/or delivery	☐ *normal*	Feeding
☐ *abnormal*		☐ *abnormal*	
☐ *normal*	Weaning	☐ *normal*	Sleeping pattern
☐ *abnormal*		☐ *abnormal*	

☐ *normal*	Motor milestones (sitting, standing, walking, first words, play)	☐ *normal*	Neuromuscular development of speech
☐ *abnormal*		☐ *abnormal*	

If yes, please describe any significant event(s):

Behavioral:

☐ *normal*	Toilet training	☐ *normal*	Phobias / recurring fears
☐ *abnormal*		☐ *abnormal*	
☐ *normal*	Reactions to beginning daycare or school	☐ *normal*	Sleeping pattern
☐ *abnormal*		☐ *abnormal*	
☐ *normal*	Habits/ repeated issues (bedwetting, hair pulling, picking, thumb-sucking, biting)	*Please indicate if you child has nightmares, night terrors:*	Frequency:
☐ *abnormal*			Duration:

If yes, please describe any significant event(s):

Social:

☐ *normal*	Age appropriate peer relationships	☐ *normal*	Age appropriate social etiquette
☐ *abnormal*		☐ *abnormal*	
☐ *normal*	Age appropriate involvement in organized groups	☐ *normal*	Age appropriate conversational skills
☐ *abnormal*		☐ *abnormal*	

If yes, please describe any significant event(s):

Hospitalizations

Have your child/adolescent ever been hospitalized?	☐ Yes	☐ No
If yes, please explain:		
Have your children/adolescent ever been hospitalized for any Psychiatric or mental health reasons?	☐ Yes	☐ No
If yes, please explain:		

Mental Health Information

Has your child ever been seen by another counselor/psychologist?	☐ Yes	☐ No
If so, how long did they attend therapy?		
What did you or your child find to be helpful?		
Has your child ever been evaluated by a psychiatrist?	☐ Yes	☐ No
If yes, please indicate psychiatrist's name:		
Would you be willing to be a part of your child's therapy?	☐ Yes	☐ No

How would you rate your child's current mental health?

☐ Excellent	☐ Good	☐ Fair	☐ Poor

Briefly describe what brings you to counseling now?
What goals would you like your child/adolescent to achieve during your therapy? (Please list at least 3)
Goal 1
Goal 2

Goal 3		
Has your child/ or adolescent experienced any life changing or stressful event(s) in the last 12 months?	☐ Yes	☐ No
If yes, please explain:		
Is your child or adolescent currently experiencing extreme sadness, grief, depressive moods, or mood swings	☐ Yes	☐ No
If yes, please explain:		
Is your child or adolescent currently experiencing fear, anxiety, panic attacks, or any kind of phobias?	☐ Yes	☐ No
If yes, please explain:		
Has the child or adolescent experienced any traumatic events in their life?	☐ Yes	☐ No
If yes, please explain:		
Does your child or adolescent engage in recreational drug use?	☐ Yes	☐ No
If yes, please list drug(s):		
Do you have any reason to believe that your child or adolescent is sexually active, sexually acting out or engaged in high risk sexual behavior?	☐ Yes	☐ No
Is your child or adolescent currently in a romantic relationship?	☐ Yes	☐ No

If yes, length of relationship:			
How do you rate their relationship?			
☐ Excellent	☐ Good	☐ Fair	☐ Poor

In the last 48 hours has your child or adolescent reported any thoughts of harming themselves or other(s)?	☐ Yes	☐ No
Has your child or adolescent ever been suicidal?	☐ Yes	☐ No
if yes, please explain:		
Are there any guns or weapons in your house?	☐ Yes	☐ No
if yes, please specify whose and what type:		
Has a family member or close friend ever committed suicide?	☐ Yes	☐ No
if yes, please specify whom.		
Is there a family history of mental illness or substance abuse?	☐ Yes	☐ No
If yes, indicate details (please list relationship and diagnosis):		

Is there any personal history of	☐ Emotional	☐ Physical	☐ Sexual Abuse	
if yes, has any abuse been reported to authorities?			☐ Yes	☐ No

If yes, indicate details:		
Has your child ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation?)	☐ Yes	☐ No
If yes, indicate details:		

Your concerns

What concerns do you have about your child?		
How long have these concerns existed?		
Have others expressed concerns about your child?	☐ Yes	☐ No
If yes, please explain:		
What do you think might be causing this?		
What have you done to cope with or resolve these issues?		
Have any of these interventions been helpful:	☐ Yes	☐ No
If yes, please explain:		
Please describe your child's personality: What are some of your child's coping skills?		
Does your child have friends or activities that you don't approve of?	☐ Yes	☐ No
If yes, please explain		

Please describe your relationship with your child:
What would you like to change about the situation?

Have you or anyone in you or your family had counseling before?	☐ Yes	☐ No
If yes, please explain (include duration and what you found to be most helpful):		
Who are the people in your child or adolescent's life who mean the most to them?		
What do you consider to be your child or adolescent's strengths?		
What do you consider to be your child or adolescent's weaknesses?		
What are your child or adolescent's interests?		

Please list names and age of any siblings your child or adolescents have.		
	Name	Age
Sibling 1		

Sibling 2		
Sibling 3		

Has anyone in your family experienced any of the following conditions? (Please check all that apply and indicate the name of the family member and relationship to you.)		
☐ Alcohol/drug abuse ☐ ADD/ADHD ☐ Anxiety ☐ Autism ☐ Depression	☐ Bipolar Disorder ☐ Domestic violence ☐ Eating disorders ☐ Obesity	☐ Obsessive Compulsive Disorder (OCD) ☐ Personality Disorder ☐ Schizophrenia ☐ Suicide (attempted or committed)

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Notice of Privacy Practices

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. A copy of your record start at $35.

- Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

- Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting the U.S. Department of Health and Human Services Office for Civil Rights by

1. Mailing a letter to:
   200 Independence Avenue, S.W.,
   Washington, D.C. 20201
2. Calling 1-877-696-6775
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- Treat you

  We can use your health information and share it with other professionals who are treating you. **Example:** A doctor treating you for an injury asks another
  doctor about your overall health condition.

- Run our organization
  We can use and share your health information to run our practice, improve your care and contact you when necessary. **Example:** We use health information about you to manage your treatment and services.

- Bill for your services
  We can use and share your health information to bill and get payment from health plans or other entities. **Example:** We give information about you to your health insurance plan so it will pay for your services.

  We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
  We can share health information about you for certain situations such as: Preventing disease, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

- Do research
  We can use or share your information for health research.

- Comply with the law
  We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- Work with a medical examiner or funeral director
  We can share health information with a coroner, medical examiner, or funeral director when an individual die.

- Address workers' compensation, law enforcement, and other government requests

  We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services

- Respond to lawsuits and legal actions
  We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

This notice is effective 10/1/2020. We can change the terms of this notice, and the changes will apply to all information we have about you.

This is to acknowledge that I have received Privacy Notice

_____

Client's Printed Name

_____

Client's Signature Client's Signature Date

ANY PROBLEMS REGARDING ETHICAL QUESTIONS AND/OR CONCERNS MAY BE DIRECTED TO THE TX STATE BOARD OF SOCIAL WORKER EXAMINERS (8407 WALL ST. AUSTIN, TX 78754) OR CALL 512-719-3521 TO ADDRESS YOUR CONCERNS OR QUESTIONS.

JoDana M. Varilek
LMSW, LCSW, LSSW, LCWS
469-414-5800
jodie@jodanavarilek.com • www.jodanavarilek.com

Fees and Billing for Psychotherapy

Fees, Billing, and Insurance

I have read the statement, considered it carefully, asked questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the session fee of $175 for a 45-55-minute session. I agree to pay the session fee if no 48-hour notification is made.

I understand that JoDana M. Varilek, PLLC is in network with most insurance companies. I understand that JoDana M. Varilek, PLLC does not file insurance claims on my behalf but has hired Headway to do so if the client wishes to bill services through their insurance company.

I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I know I can end therapy at any time and that I can refuse any requests or suggestions made by the therapist. I am over the age of eighteen.

Automatic Billing Authorization

I authorize to charge my bill from JoDana M. Varilek, PLLC, directly to my credit card(s) listed below. This authorization is valid until I provide you with WRITTEN cancellation. Credit Card transactions will appear on your bank statement as JoDana M. Varilek, PLLC. These charges include, but are not limited to:

Usual and Customary Fees:

Initial	Service
	Individual and Family Sessions at a rate of $175.00 per 45-55 minutes
	Late cancellations without 48 hours' notice or missed appointments at a rate of $175.00 per 45-55 minutes

	Phone Sessions: 10 minutes or less = no charge 11-20 minutes = $55 (one third of session rate); 21-30 minutes = $82.50 (one half of session rate) 31-55 minutes = $175 (full session rate)

Court Appearances and associated fees:

Initial	**Service**
	Non-refundable retainer fee of $1,500
	$400 for every hour of my time involved including case preparation, travel and witness time

There may be fees for the use of certain psychological assessments, the fees for which will be discussed prior to their use.

Credit Card Information:

Name as it reads on card:			
Type of Card	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express		
Expiration Date		Card Number	
CVV Number			

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ. UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

I strongly urge you to obtain a copy of the consent for your records. If you have questions about any of the information on this form, or you have any complaints about the procedure, please discuss them with your therapist.

I am looking forward to working with you.

_____

Client's Name Client's Signature Date

JoDana Varilek, PLLC
www.jodanavarilek.com
469-414-5800
jodie@jodanavarikek.com

CLIENT FEE CONTRACT 2020

As a professional courtesy, I agree to adjust your out-patient fee from $175.00 for each 45-55minute session to:

Rate: _____ Until (date) _____

Signed: _____ Date: _____

I understand that any money recuperated from any 3rd party entity is the property of JoDana Varilek, PLLC. and will not be refunded to me. This is including, but not limited to, managed care companies and insurance companies. If my financial situation changes, I will notify JoDana Varilek, PLLC. in writing for a reassessment of the applicable Adjusted Fee rate. If my credit card is declined at the time of my session or on the day the payment is scheduled to be deducted, I agree to pay JoDana Varilek's standard out-patient fee of $175.00.

My signature below indicates acceptance of this agreement. I understand that on expiration of this Adjusted Fee Contract on the date provided above, my fee will return to the standard rate and I will accept full responsibility for my standard appointment fees.

Client Signature: _____ Date: _____

Client Printed Name: _____

ADJUSTED FEE SCALE – 2020

JoDana Varilek, PLLC. Adjusted Fee Scale rates are based on the client's net household income. In the case of a divorce, if the parents have joint managing conservatorship, it will be required that both parents provide their net household income.

Verification of income is required to determine the Contracted Adjusted Fee, prior to the initial session in 2020. Current pay stub(s), direct deposit advice, or most recent household tax return will serve as appropriate verification.

Adjusted fee Scale - 2020

Adjusted Fee	Net Yearly Income	Net Monthly Income	Net Weekly Income
$150	$36,000 - $39,000	$3,000 - $3,333	$693 - $769
$140	$32,000 - $35,999	$2,499 - $2,999	$577 - $692
$130	$28,000 - $31,999	$2,333 - $2,498	$539 - $576
$120	$24,000 - $27,999	$2,000 - $2,332	$462 - $538
$110	$23,999 and below	$1,999 and below	$461 and below

Net household Income verification is performed via current pay stub(s) or current income tax return.

JoDana M. Varilek
LMSW, LCSW, LSSW, LCWS
469-414-5800
jodie@jodanavarilek.com • www.jodanavarilek.com

Authorization for Release of Information

If you want your clinician to share information about you with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with.

SECTION I

I, _____ give my permission for my clinician to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information
Please describe the information you want your clinician to share about you. Please include any

dates and details you want to share: _____

_____

B. Permission about Specific Health Information.
Only if you choose to share any of the following information, please write your initials on the line:

____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by law shall be included prohibiting the redisclosure of this confidential information.

____ I specifically give permission to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____ I specifically give permission to share information in my record about details of mental health diagnosis and/or treatment provided by a psychiatrist, psychologist, mental health clinical nurse specialist, or licensed mental health clinician (LMHC)

____ I specifically give permission to share information in my record about confidential communications with a licensed social worker.

____ I specifically give permission to share information in my record about details of domestic violence victims' counseling.
____ I specifically give permission to share information in my record about details of sexual assault counseling.

_____ Other: (Please specify) _____

SECTION III – Reason for Sharing This Information
Please initial the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request" if you are initiating the request in the other section.

_____ Coordination of care

_____ Clinical consultation

_____ Transfer of care

_____ Insurance

_____ Patient is a minor

_____ Other: (Please specify) _____

SECTION IV – Who May Share This Information
I give permission to the person or organization listed below to share the information I listed in Section II:

SECTION V – Who May Receive My Information (This could be your primary care doctor, another medical professional or personal representative who is helping with your treatment)
The person or organization listed in Section IV may share the information I listed in Section II with this person(s), organization or representative:

Name: _____

Organization: _____

Address: _____

Phone: _____

Fax: _____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until _____. If I do not list a date or event above, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to JoDana M. Varilek, and send it to jodie@jodanavarilek.com. If the information has already been given out prior to the time my permission has been withdrawn, I understand that it is too late for me to change my mind and cancel the permission.
- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION VII – Signature

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Describe how this person has legal authority for this individual (if you are a parent, write

"parent": _____

_____ _____

Signature: Date: