

GLORIA MARTIN MA, LPC-S, LMFT-S

LICENSED PROFESSIONAL COUNSELOR ** LICENSED MARRIAGE & FAMILY THERAPIST

Welcome

Welcome to my private practice and thank you for choosing to work with me. My role as a therapist is to help you recognize your needs and wants, and to offer you support during the process of healing and growth. My therapeutic philosophy is a strength-based approach that is based on my belief that you are the expert of your life. We will work together to discover the best way for you to find answers to your problems. I look forward to our work together.

Credentials and Services

In my private practice I provide services to individuals, couples, families and teambuilding for companies. I have met the requirements set by the Texas State Board of Health for Licensed Professional Counselors (LPC) and Licensed Marriage and Family Therapists (LMFT). I hold a Bachelor of Science degree from Auburn University in Family and Child Services. I have a Master of Arts degree from the University of Houston-Clear Lake with an emphasis in Family Therapy. I provide supervision and training as an AAMFT Clinical Supervisor. I am a trained Marriage Enrichment Leader by the Association of Couples for Marriage Enrichment. I am certified to administer and interpret the Prepare/Enrich Inventory. Additionally I have participated in clinical research showing the efficacy of the use of Emotionally Focused Couples Therapy as a treatment for depression. Additionally, I am certified to administer and coach using the Brainstyles Instrument.

Office Policies and Procedures

Please read and review carefully all the following information signing where it is indicated. These informational documents outline your rights of confidentiality as a client and my role and responsibility to you. I will provide you with a copy of all signed documents at your request. Individuals who have seen therapist in the past may find forms that are not familiar. One difference is the HIPPA form, as therapists have not been required to have a HIPPA form on file. However, we are now required to keep HIPPA forms on file.

Confidentiality and Informed Consent

The therapeutic relationship requires complete confidentiality between client and therapist. Information about clients, including case notes and records are confidential and are the property of Gloria L. Martin MA, LPC, LMFT. In the event of my being unable to perform professional services, i.e., death or extreme disability, one of my colleagues, Carrie Beard, LPC, LCDC or Dr. Susan Leonard, LMFT will safeguard your file according to state and national ethics rules and regulations.

The Texas Health and Safety Code has established the following limits of confidentiality. You should be aware of these **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, your therapist has a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

By signing below, you are stating that you have read and understood the rules of confidentiality.

Signature of Family Member I

Date

Signature of Family Member II

Date

Signature of Family Member III

Date

Signature of Family Member IV

Date

Patient Privacy Notice (HIPPA)

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.

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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.

Please answer yes or no and circle your wishes stating that you understand that, and consent to the following appointment reminders that may be used by the Provider:

Family Member 1

Yes **No** - You **may/may not** leave a message on my work voicemail.

Yes **No** - You **may/may not** contact me by email at my personal email account

Yes **No** - You **may/may not** contact me by email at my business email account

Yes **No** - You **may/may not** contact me and leave a message on my cell phone.

Yes **No** - You **may/may not** send text messages to me.

Family Member 2

Yes **No** - You **may/may not** leave a message on my work voicemail.

Yes **No** - You **may/may not** contact me by email at my personal email account

Yes **No** - You **may/may not** contact me by email at my business email account

Yes **No** - You **may/may not** contact me and leave a message on my cell phone.

Yes **No** - You **may/may not** send text messages to me.

Family Member 3

Yes **No** - You **may/may not** leave a message on my work voicemail.

Yes **No** - You **may/may not** contact me by email at my personal email account

Yes **No** - You **may/may not** contact me by email at my business email account

Yes **No** - You **may/may not** contact me and leave a message on my cell phone.

Yes **No** - You **may/may not** send text messages to me.

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Family Member 4

_____ **Yes** _____ **No** - You **may/may not** leave a message on my work voicemail.

_____ **Yes** _____ **No** - You **may/may not** contact me by email at my personal email account

_____ **Yes** _____ **No** - You **may/may not** contact me by email at my business email account

_____ **Yes** _____ **No** - You **may/may not** contact me and leave a message on my cell phone.

_____ **Yes** _____ **No** – You **may/may not** send text messages to me.

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. You may file a complaint with us by notifying our Privacy Manager of your complaint.

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

Signature – Family Member I

Signature – Family Member II

Signature – Family Member III

Signature – Family Member IV

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Fee Agreement and Payment

There are three ways to make payment, which I will outline in this section of the office policies. I accept cash, checks, all major credit cards and flex-spending account cards.

I prefer payment of your fee at the start of your therapy session as this maintains your privacy and is respectful of the next client's need for promptness. You are responsible for payment of your fees at the time of service. This process insures that we devote the optimal time to working on your behalf.

Fee-for -Service

Paying for your therapy sessions using the fee-for-service method is best. It is the only way that I have to assure complete confidentiality of our sessions. It also is the best value because my time is devoted to working with you and not spent filing paperwork with your insurance company. My fee for service is \$140 for a 50/60-minute session.

Insurance

I am a preferred provider for Blue Cross & Blue Shield and PHCS. If you are covered by one of these plans I will file with your insurance carrier and collect a co-pay from you. If you are not covered by one of these plans and want to use insurance, I am happy to provide you with an invoice that you can file with your carrier.

I do not control coverage or payment as a service provider. While I take my role in coordinating benefits and complying with your insurance company's request seriously, I rely on you to follow the procedures outlined for you in your benefit plan document. If you do not follow your plan's procedures, you will be responsible for all fees incurred. Please take time to check on these.

Please be aware that if you choose to use your insurance you are forfeiting some of your rights to privacy and confidentiality. Insurance companies require that mental health providers assign a psychiatric diagnosis and that diagnosis is then transmitted to your insurance company. Most insurance filing is done via the Internet over a secure server; however there is no way for me as your therapist to ensure your confidentiality.

Other Payment Options

I am committed to working with you and I have placed a fair market value on the services I provide. However, I do not want an insurance company's allowed sessions, a job loss, or other crisis to impede the therapeutic process. Consequently I will offer some sliding fee appointments that will be based on need and necessity.

There is a \$25.00 return check fee.

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Court Action Policy and Fees

Clients are discouraged from having Gloria Martin, MA, LPC, LMFT subpoenaed or having her provide records for the purpose of litigation. I am trained as a family therapist and my work and therapeutic philosophy comes from non-adversarial position. I have not been trained forensically or with the expertise to appear in court.

I am unable to guarantee that any testimony that I am required by law to give will be solely in your favor. I can only testify to the facts of the case and my professional opinion.

If Gloria Martin, MA, LPC, LMFT is to receive a subpoena then the attorney or office staff will need to call my office and set up a time for the subpoena to be served during office hours. I request a minimum of 72 hours notice of any Court appearance so that schedule changes for my clients can be made within a reasonable time frame.

Please note: if a subpoena is received without a minimum of 72 hour notice there will be an additional \$250 express charge.

Court action fees are as follows:

- 1. Preparation Time: \$250.00 per hour
(billable in 15-minute increments)
- 2. Phone Calls: \$150.00 per hour
(billable in 15-minute increments)
- 3. Filing Document with court \$100.00
- 4. Minimum charge for court appearance \$2,000.00 for half day
\$4,000 for full day
- 5. Attorney fees: I agree to pay all attorney's fees and costs that are incurred by Gloria L. Martin as a result of any court action.
- 6. Retainer: A retainer of \$1,000.00 is due at least 72 hours before the scheduled appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt.

If a therapist is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given then the client will be billed \$1,000.

Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

Signature Family Member I

Date

Signature Family Member II

Date

Signature Family Member III

Date

Signature Family Member IV

Date

Other Important Information About My Practice

Office Hours

My office hours are 9:00 a.m. to 5:00 p.m. I begin seeing clients at 9:00 and the last appointment available is at 5:00, Monday through Thursday.

Appointments

I will make every effort to make appointments that are convenient for you. Appointments are made on the hour and are 60 minutes in duration. The frequency of appointments will be discussed at the first session.

Therapist/Client Communication

Charges will be made for client initiated telephone calls that exceed fifteen minutes, as well as letters, or reports requested by you. The rate for phone calls, letters or reports will be prorated depending on the length of the call or preparation time.

I do not do therapy via electronic device, i.e. email or text. I believe that your confidentiality is violated in the process and emails and text are subject to subpoena if part of your file. However, I am happy to do appointment scheduling via email.

Communication between Therapist and Couples

When working with couples, the relationship is my client. The best couple work happens when communication is open between all parties. Maintaining a neutral therapeutic environment is extremely important to me. Consequently, I will not keep secrets, accept emails that are sent to only one person, or have phone conversations about the other party. I will be happy to schedule an individual appointment to provide opportunity for processing unresolved issues.

Cancellation Policy:

If you find it necessary to cancel an appointment during normal business hours, please leave a message at 214-890-4047 or by e-mail at gloria@discoveringgrowth.com. You may also leave a message at any time day or night, weekends or holidays.

You will be charged for appointments missed without 24-hour notice of cancellation unless it is an extreme emergency.

****Please Note****

If you are using insurance benefits to pay for sessions, insurance companies do not reimburse for missed appointments. Therefore if a client is being seen through insurance the fee for a missed appointment without 24-hour notice is the reimbursed rate that the insurance company pays and not the co-pay.

Emergency Calls

I do not use an answering service and I check my voice mail several times during the day and during the weekend. You may reach me by cell 469-855-0515 during the weekend if there is an emergency.

If there is an extreme life threatening emergency you will need to call 911 or go to the emergency room of the nearest hospital.

The following numbers may also be helpful:

- **Crisis Hotline: 972 233-2233**
- **Suicide Hotline: 214-282-1000**

Snow/Ice Days – Emergencies

My office will be closed if the Dallas Independent School District (DISD) closes school due to weather conditions. However, if there is snow or an icy condition, I want you to feel safe. You may call to cancel your appointment and the 24-hour notification policy will be waived.

Responsibility for Treatment

As with any other procedure, psychotherapy involves some risks. Whenever you make significant changes in your lifestyle, outlook or habits, your life and the lives of those with whom you are closely involved will be affected. While the purpose of psychotherapy is to make changes, you will want to consider the consequences that might arise. Whatever changes you make will be both your choice and your responsibility. If you become concerned about the course of your therapy, please let me know so that you can have the course of treatment best for you.

Ending Therapy

The end of therapy is an important process. It is a time to review, to recognize progress, to note areas in which you want to continue growth. It is also a time to receive feedback and encouragement. When you are ready to discontinue therapy, please discuss this at the beginning of your appointment in order to have therapeutic closure.

Complaints and Grievances:

I make every effort to provide services that are pleasing to you. If you believe I have failed to provide satisfactory care or have acted unprofessionally or unethically, please let me know, so I am able to correct this. To file a grievance with my licensing boards, you may write to:

Texas State Board of Examiners of Professional Counselors
1100 W. 49th St.
Austin, Texas 78756

Texas State Board of Examiners of Marriage and Family Therapists
1100 W. 49th St.
Austin, Texas 78756

Agreement

I have read the above and accept the foregoing policies. A copy of this form is valid as the original. I certify that I am an adult over sixteen years of age and consent to the above conditions for therapy.

Signature – Family Member 1

Date

Signature – Family Member 2

Date

Signature – Family Member 3

Date

Signature – Family Member 4

Date