Carrie Boyd Lutter, LCSW, RD
www.carrielutter.com
2770Main St., Suite 124, Frisco, TX / 214.662.5549

PRACTICE POLICIES AND CONSENT

I welcome you! It is my desire to insure that your participation in counseling will be a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information which will enable you to make an informed consent to counseling.

Therapist Qualifications: My name is Carrie Boyd Lutter and I am licensed by the States of Texas and Iowa to provide mental health and medical nutrition therapy services. I am a member of the National Association of Social Workers and hold the following licenses/certifications: Licensed Clinical Social Worker (LCSW); Licensed Independent Social Worker (LISW); Registered Dietitian (RD); Certified Personal Trainer (CPT); and Certified Aerobics Instructor. I have an independent clinical practice in Frisco, Texas where I specialize in treating eating disorders, body image concerns and family feeding dynamics.

Mental Health Services: While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will achieve change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future, 3) move toward resolving your concerns, and 4) forge a life plan that promotes greater realization of your human potential, happiness, and success. As your therapist, using my knowledge of human behavior and human change process, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you or I feel it would be helpful.

Effects of Therapy: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspective and decisions you make. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Risks of Therapy: Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the effort you are prepared to give to this endeavor and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

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Client Rights: Some clients only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do request you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be beneficial to you.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please notify me in person or in writing and I will work with you to resolve your concerns. It is my pledge that any problems will be resolved to your satisfaction.

Relationship: Your relationship with me is a professional and therapeutic one. In order to preserve this relationship, it is imperative that I have no other relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to have a social or personal relationship with you. Gifts, bartering and trading services are specifically disallowed in the legal code of ethics of my profession.

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

Telephone Accessibility:
If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

Emergency Services: I am unable to provide 24 hour per day, seven days per week psychotherapy services. In the event that you become in need of emergency services when I am unavailable, you may contact the following: **Dial 911 or Tarrant County – Crisis Intervention – Fort Worth at (817) 927-5544; John Peter Smith Hospital Emergency Room at (817) 927-1110. Dallas County – Dallas Suicide and Crisis Center at (214) 828-1000; Parkland Psychiatric Clinic at (214) 590-5536 or the Parkland Emergency Room at (214) 590-8761.**

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Appointments: ***Sessions are usually held for 50 minutes.*** Persons are seen in the office on an appointment basis. Initial appointments may be made by calling (214) 662-5549. Since I maintain my own appointment calendar, it is best to leave your name and number in my confidential voice mailbox and I will call you back for scheduling the appointment. Appointments are for 50 minute sessions.

Cancellations: Cancellations must be received **at least 24 hours** before your scheduled appointment; otherwise **you will be charged the full appointment fee for that missed appointment.** You are responsible for calling to cancel or reschedule your appointment. The reason for this is that when you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my work day.

Payment for Services: A flat rate of $150.00 is charged for psychotherapy and medical nutrition services per 50 minute session. The fee is payable at the beginning of the session unless other arrangements have been made. **Payment will be made to Carrie Lutter, LCSW, RD by check, cash, credit, or debit card**. There will be a $30.00 fee for returned checks. All transactions are fee for service and insurance is not accepted. Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below.

In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and my normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered.

If you are involved in a divorce or custody litigation, you need to understand my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in litigation. By signing this document, you agree not to call me as a witness in any such litigation. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

Confidentiality: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should

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bring them to my attention when we discuss this matter further. By signing this information and consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless this therapist from any departure from your right of confidentiality that may result.

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.

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

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

Duty to Warn: In the event my therapist reasonably believes that I, the undersigned client, am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and **to contact the following persons**, in addition to medical and law enforcement personnel (please print):

Name(s)	**Telephone Number(s)**	**e-mail Address(es)**

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I, the undersigned client, consent for my therapist **to communicate with me** by mail and phone, at the following addresses and phone numbers and I will IMMEDIATELY advise the therapist in the event of any change (please print):

My Mailing Address	**My Telephone Number(s)**
_____	_____
_____	_____
_____	_____

Therapist's Incapacity or Death: I, the undersigned client, acknowledge that, in the event my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by my therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Voluntary Consent to Treatment: I, the undersigned client, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. However, premature termination may result in failure to achieve therapeutic outcomes.

By signing this Practice Policies and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____	_____
Client/Parent/Legal Guardian	**Date**
_____	_____
2nd Client/Parent/Legal Guardian	**Date**

As witnessed by:

_____	_____
Carrie Boyd Lutter, LCSW, RD **Therapist**	**Date**

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PERSONAL INFORMATION (Please Print)

Date _____ Social Security _____

Name _____
Last First MI

Address _____
Street City Zip

E-mail Address _____

Telephone (Home) _____ (Work) _____
(Cell) _____ & Cell Phone Carrier _____

IN THE EVENT OF AN EMERGENCY, I give Carrie Lutter, LCSW, RD permission to contact: Name _____ Relation _____ Phone _____

Is it OK to leave messages on your answering machine and/or voice mail or with a family member/roommate? Yes ____ No ____

Is it OK to mail correspondence to above address? Yes ____ No ____

Date of Birth _____ Age _____ Gender _____ Race _____

Married ____ Single ____ Divorced ____ Widowed _____ Cohabitation _____

Name of Spouse or Partner _____

Date of Birth (Spouse or Partner) _____ Age _____

Your Education: Years or grades completed _____ Degree(s) earned_____

Types of coursework taken: _____

Occupation _____

Employer _____ How long in present job ? _____

Employer (Spouse or Partner) _____ How long in present job? _____

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PERSONAL INFORMATION continued (Please Print)

Primary Care Physician _____ Physician's Phone _____

List any present medical conditions and current medications

_____

_____

Have you had previous therapy/counseling/psychiatric care? Yes ____ No ____

If yes, when and with whom? _____

Please describe the experience:

How were you referred to me?

Patient Information if client is a minor:

Parent/Legal Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Occupation _____ Education Level _____

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EMAIL AND TEXTING CONSENT

HIPAA regulations and my professional Code of Ethics both require that I keep you Protected Health Information private and secure, and indeed I want to do so. Email and texting are very convenient ways to handle administrative issues like scheduling or receipt requests, but email and texting are not 100% secure. Some potential risks you might encounter if we email and/or text include:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be "hacked", giving a 3rd party access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, Yahoo) keep a copy of each email on their servicers, where it might be accessible to employees, etc.
- Cell phones can be lost or stolen, possibly giving a 3rd party access to email and/or text content.
- Texts may be accessible to a 3rd party in your home or workplace.

For these reasons, I will not use email or texting to discuss clinical issues (i.e., the important things we talk about in session.)

If *you* are comfortable doing so, I am happy to use email and/or text to handle small administrative matters like scheduling and billing.

If you are *not* comfortable with these risks, we can handle administrative issues via phone calls.

Please indicate your preference about email and texting below and sign.

I DO DO NOT consent to use email for administrative matters.

I DO DO NOT consent to use texting for administrative matters.

If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email, although you are always still welcome to email me, and I can reply briefly if you do.

_____ _____

Name **Date**

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CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **Date of Birth**: _____

Parent/Legal Guardian Name: _____
(Applies only if client is under 18)

I hereby consent to participating in psychotherapy or nutrition services with Carrie Lutter, LCSW, RD and understand that all information I provide is private, confidential, and protected by law as described in the Privacy Practices. When necessary to coordinate my treatment and healthcare, and as described in the Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company: _____ Primary Care Doctor: _____

Address: _____

Phone: _____ Fax: _____

Other Doctor or Provider: _____ (Relationship: _____)

Address: _____

Phone: _____ Fax: _____

Psychologist or Counselor: _____

Address: _____

Phone: _____ Fax: _____

Carrie Lutter, LCSW, RD is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Carrie Lutter, LCSW, RD at the address above. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Client/Parent/Legal Guardian Signature: _____ Date: _____

(This section below applies only to patients who are less than 18 years of age.)
I hereby give permission for my child to receive counseling with Carrie Lutter, LCSW, RD without a parent or guardian present, and I release Carrie Lutter, LCSW, RD from any and all liability for any incidents or injuries that may occur during my child's appointment or when my child is traveling to or from his/her appointment. I understand that information discussed during counseling sessions will not be released to parents against a minor child's will, except for information of a life threatening nature. In all cases, a minor child will be encouraged to share appropriate information with a parent.

Parent/Legal Guardian Signature: _____ Date: _____

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CLIENT FEE AGREEMENT

1. Standard fees for psychotherapy and medical nutrition services are $150.00 per 50 minute session. Body composition and metabolic measurements are $75.00.

2. Payment will be made to Carrie Lutter, LCSW, RD by check, cash, credit, or debit card.

3. Payment plans are available if prior arrangements have been made.

4. There will be a processing fee of $30 for returned checks.

5. Cancellations must be received **at least 24 hours** before your scheduled appointment; otherwise **you will be charged the full appointment fee for that missed appointment.** You are responsible for calling to cancel or reschedule your appointment. The reason for this is that when you make an appointment you are reserving a time. As your therapist/dietitian, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my work day.

6. My method(s) of payment will be (please check all that apply):

____ Cash ____ Personal Check ____ Debit Card ____ Credit Card

Debit/Credit Card Authorization

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name as it appears on card:_____ Date of Birth:_____/_____/_____

Card Number:_____ Expiration Date:_____/_____

Last 3 or 4 numbers from front/back of card _____

Your Billing Zip Code (typically same as mailing zip code) _____

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me. I also understand that payment is due at the time of the session unless prior arrangements have been made. My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission to charge my debit/credit card for any appointment which is not paid for any reason the day of service, or for any appointment that is not cancelled in the timely manner described above.

Client Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

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.

LEGAL DUTY AND COMMITMENT TO YOUR PRIVACY

To my clients: My practice is dedicated to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act of 1996, known as HIPAA, I am required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I provide each client (and client's parent, for those under 18 years of age) with an authorization form to allow me to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

I am also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; for National Security; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that I make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death.

I may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, I will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

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YOUR INDIVIDUAL RIGHTS

Communications: You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home rather than at work. I will accommodate reasonable requests.
Restrictions: You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict disclosure of your health information to only certain individuals involved in your care or the payment of your care. I am not required to agree with your request. However, if I do agree, I am bound by our agreement except when specifically authorized by you, otherwise required by law, in emergencies, or when the information is necessary to treat you.
Inspect and Copy: You have the right to inspect or obtain a copy of the health information that may be used to make decisions about you for as long as the PHI is maintained in the record. I may charge a fee for costs related to your request. I may, under certain circumstances, deny your request but if I do, you can obtain a review of that denial by another licensed health care professional that I designate.
Amend: You have the right to request an amendment by me of your health information if you believe it is incorrect or incomplete, as long as this information is kept by and for my practice. Your request must be made in writing and submitted to me at the address above. You must provide a reason that supports your request. I have the right to deny such a request under certain circumstances.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Health and Human Services. To file a complaint with my practice, contact me at the address above. All complaints must be in writing. You will not be penalized or retaliated against for filing a complaint.
Other Authorizations and Accounting: My practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law. You also have the right to receive an "accounting", which lists certain instances when I have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, I may charge for costs related to additional requests.

CHANGES IN NOTICE OF PRIVACY PRACTICES

I may change the privacy practices at any time and the new terms shall apply to all PHI about you that I have at the time of the change and to all PHI about you that I maintain in the future. If any material changes are made, I will change the Notice of Privacy Practices and post it in the waiting area of my office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of the Notices of Privacy Practices at any time.

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES FOR CARRIE LUTTER, LCSW, RD

Please sign and return this page.
You may keep the Notice of Privacy Practices for your records.

Client Name (printed) _____

Date of Birth _____/_____/_____

Parent/Guardian Name (if client is under 18) _____

I acknowledge receiving a copy of and have been given an opportunity to read a copy of the Notice of Carrie Lutter's Privacy Practices on _____/_____/_____.

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Carrie Lutter at the address and phone number above.

_____
Patient Signature (or Parent/Guardian signature if client is under 18)

For Office use only.
If written acknowledgment was not obtained, please explain below: