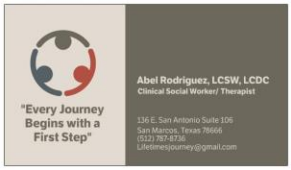


Welcome and thank you for choosing Abel Rodriguez, LCSW, LCDC for your psychotherapy needs. I am honored for the opportunity to work with you. I understand beginning the process of psychotherapy may be a major decision and you may have many questions. This document is intended to inform you of my office policies, state and federal laws, and your rights and responsibilities. If you have any questions or concerns, please ask and I will do my best to provide you all of the information you need.

Effective psychotherapy is founded on mutual understanding and collaboration between patient and therapist. My goal is to create a supportive environment in which patients can explore emotional needs and overcome barriers that limit their full potential. I take an open-minded approach to the patient's wellness and consider how the individual patient's mental, physical, emotional, social and spiritual health impacts their specific situation.

CONSENT TO TREATMENT

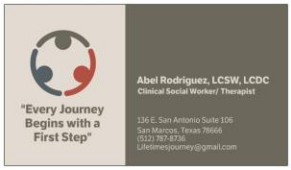
_____ _____

Patient Name **DOB/Age**

PROVIDER: Abel Rodriguez holds a Master's Degree in Social Work from Texas State University - San Marcos, completed 3,000 supervised hours, and passed all required exams to be independently licensed as a Clinical Social Worker through the Texas Board of Social Work Examiners. Abel Rodriguez has an additional license as a Chemical Dependency counselor through the Texas Department of State Health Services. If you have questions, concerns or complaints, I hope you feel free to raise concerns with me so we can work to resolve concerns together. If we are unable to reach a satisfactory solution you can direct inquires and complaints to the Texas State Board of Social Work Examiners at 1100 West 49th Street, Austin, TX 78756-3183 or 800-232-3162.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personality of the psychotherapist and the patient and the specific issues you bring. There are many different methods for addressing issues you hope to resolve. Psychotherapy calls for a very active effort on your part. In order for therapy to be most successful, you may be asked very personal questions that may provide a greater insight to one's situation. You may also be asked to work on things we discuss both during our sessions and at home, in the community, in relationships, or where ever the issues reside.

While beneficial, psychotherapy can also have risks. Since psychotherapy therapy often involves remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, and helplessness, or experiencing anxiety, depression, insomnia. Psychotherapy has also shown to have great benefits for people who go through the process. Psychotherapy therapy often leads to an improved relationship, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Each person is unique.



The first session involves an evaluation of your needs. At your next session, Mr. Rodriguez will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with psychotherapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with Mr. Rodriguez. If you have questions about the procedures, we should discuss them as they arise. If your doubts persist, I can link you to another mental health provider for a second opinion.

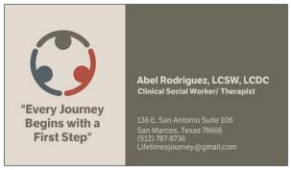
CONFIDENTIALITY & LIMITATIONS: All communication with Mr. Rodriguez is confidential except under circumstances explained below be disclosed to anyone outside of my practice unless you have given written authorization to release information (or in the case of a minor the parent or legal guardian).

A record is kept of your work with Mr. Rodriguez. It contains information you have provided in writing, as well as counseling notes of your sessions. The record remains with Mr. Rodriguez for a period of seven years following your last visit and at that time it is destroyed. Your records do not leave my possession.

In order to ensure CONFIDENTIALITY, I will only see you by appointment or by agreed time in my office. If I see you outside the office, I will not approach you and may even walk the other way; if you approach me, I will be friendly, but will not discuss your issue nor indicate the nature of our relationship unless you make it clear that you want the relationship known.

Furthermore, it is important that you understand all identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person about clients is not provided. Your will need to sign a consent to release information before any information is provided to a 3rd part outside of this office. This condition applies to cases where coordination of treatment is necessary with another health professional (e.g. physician, psychiatrist). However, there are exceptions and/or limitations of confidentiality. The following are some exceptions that allow or require the release of confidential information, without client consent. Examples include:

- If you give me a signed authorization to release the information.
- In cases of immediate risk/threat of suicide or homicide on the part of the client.
- In cases of child or elderly abuse or neglect.
- In cases required by law or court order or a subpoena. (I will try to provide you advance notice of subpoena or court order).
- In case of consultation. As professionals, we do consult with one another from time to time. Any clinical material is conveyed without identification whenever possible. At other times, it will be necessary (for example, if another therapist is covering calls during vacation).
- Case material is sometimes used in training, research, writing etc. This is always done with identifying information removed and with great care and respect for privacy.
- In order to collect fees, information can be released to the third party payor.
- To qualified personnel for management or financial audits (insurance or government audits.)
  Initial_____



INCAPACITY OR DEATH: I understand in the event of the death or incapacitation of Mr. Rodriguez, it will be necessary to assign my case to another therapist for the therapist to have possession of my treatment records. By my initials on this form, I hereby consent to another licensed mental health professional, selected by Mr. Rodriguez, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing. Initial_____

EMERGENCY SITUATIONS: Abel Rodriguez, LCSW, LCDC does not provide emergency services, though Mr. Rodriguez tries to be available as is reasonably possible. You may call the office number at any time and leave a message, if Mr. Rodriguez is unable to answer. During the business day, Mr. Rodriguez can often, though not always, return calls fairly quickly. Nighttime and weekend calls are usually returned the following business day. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the National Suicide Prevention Lifeline a 24-hour crisis line at (1-800) 273-8255, the Police (911), or the Hays County Mobile Crisis Outreach Team, a 24-hour psychiatric emergency number at 1-877-466-0660. Initial_____

DUTY TO REPORT: I am a mandatory reporter which means I have a legal obligation to report to authorities if I believe a child, a disabled person, or elderly person is being abused or neglected. I have legal obligation to report to authorities if I believe you are an imminent physical danger to someone else, or an imminent physical, mental or emotional danger to yourself. Initial_____

TERMINATION: It is usually most beneficial for therapist and client to discuss the termination process and I encourage you to do so. However, if I have no contact with you for two months, I will automatically terminate the case without further notice. It is always easy to re-open a case, so we can do so if you contact me again. You will need to complete new "Consent to treatment and financial forms" again. Initial_____

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

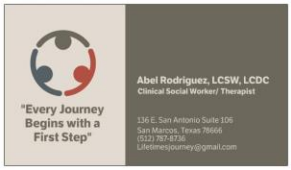
While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better and there is no guarantee of success in therapy. There may be alternative treatments or modes of therapy to consider. I will encourage you to become aware of these factors and to ask any questions you may have at any time during our work together.

_____ _____

Print Name Signature Client/Guardian Date

_____ _____

Signature Therapist Date



FINANCIAL POLICIES

FEES ARE CHARGE FOR THE FOLLOWING:

- Therapy Sessions (Individual, family, couples or group)
- Non-cancelled appointments or those missed without 24 hour prior notice.
- Preparing/copying records, reports, court appearances and letters.

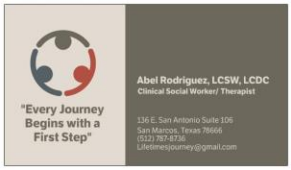
CANCELATION POLICY: I understand that my appointment reserved at this time is exclusively for me and if I do not cancel or re-schedule my appointment with at least 24 hours' notice, I will be responsible for a fee of $25.00. Checks returned for insufficient funds will be charged a $25.00 fee. Initials_____

SESSIONS: Appointments are usually scheduled for at least 50 minutes, and an Initial Diagnostic & Evaluation Session are schedule for 90 minutes. During this time, you and Mr. Rodriguez both decide whether this is the best therapeutic fit for your needs and best meet your treatment goals. If a treatment plan is agreed upon, sessions are typically one 50-minute session weekly or according to your needs.

COURT APPEARANCES: It is the policy of Mr. Rodriguez to avoid court appearances whenever possible. As mental health professionals, we view our role in an individual's or family's life to be one of assessment and treatment, not to provide testimony in a legal setting. Please be advised that the only time I will appear in court is when required by court and issued a subpoena. Attending and preparing for court hearings is time consuming and costly, not only to Mr. Rodriguez, but to other clients as well.

Attending court requires that all clients be cancelled and re-scheduled during that time, which may delay, inconvenience or prohibit their ability to receive needed services. This time demand directly impacts Mr. Rodriguez's ability to maintain his commitment and services to all her clients. It is important that clients understand that testimony in court may or may not help your case.

If required to testify, the only information that will be provided is any truth of which there is firsthand knowledge. Fees for court testimony are: $300.00 per hour, beginning from the time of departure from the office until return to the same location, with a minimum of three hours billed. Fees are also required for copying of records or creating summaries or documents for court. Fees are due 24 hours prior to any court appearance. Initial_____



FEE POLICY: My policy is to request payment of fee for services rendered at the end of each session. You can elect to pay using the Private Pay Fee, Private Pay using a sliding scale, you can plan to use your insurance, or you have made arrangements with your Employee Assistance Plan.

PRIVATE PAY FEE:

My fee for service rate is $125 for initial diagnostic and evaluation visit and $100 for a regular session when paying out of pocket or if you have not met your deductible. If I am consider an "out of network therapist" and if you wish to bill your insurance company, I will provide you with a statement at time of services rendered, but I do not or cannot guarantee reimbursement by your insurance company.

Mr. Rodriguez is an Eye Movement Desensitization Reprocessing (EMDR) basic trained therapist and if EMDR is the best fit for you, your sessions will be 90 minutes at $125.00 a session.

PRIVATE PAY USING A SLIDING SCALE FEE:

I do utilize a sliding scale and if you wish to pay off a sliding scale, your fee will be based off your household size and gross household income.

I attest that my household size ____ and my gross household income is _____.

I PLAN TO USE MY INSURANCE:

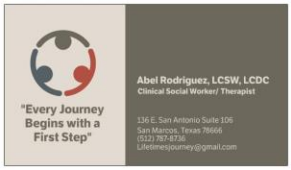
IF YOU HAVE MET YOUR DEDUCTIBLE OR YOUR HAVE A COPAY; YOU WILL ONLY BE CHARGED WHAT YOUR INSURANCE AGREES TO BE THEIR and YOUR RESPONSBILITY. SHOULD YOUR INSURANCE STATE THAT YOU HAVE NOT MET YOUR DEDUCTIBLE YOU WILL BE RESPONSINLE FOR THE OUTSTANDING BALANCE. Initial_____

I PLAN TO USE MY EMPLOYEE ASSISTANCE PLAN:

Name of EAP: _____
Phone Number: _____
Authorization Code: _____
Number Session Authorization Code: _____ Initial_____

FEE AGREEMENT:

The following is a fee agreement between you and Abel Rodriguez, LCSW, LCDC. You are expected to pay $_____ for the Initial Diagnostic & Evaluation Session and for each regular Office Visits in the amount of $_____at the beginning of each session. Initial_____



The purpose of this section is to allow your therapist to bill your insurance company and obtain authorization for treatment.

Insured's Plan Name:_____
Insured's Policy Group#:_____
Issuer#:_____
Insured's ID#:_____
Insurance Provider Address#:_____
Insurance Provider Phone#:_____

Insured's Employer/School's Name: _____
Policy Holder:_____
Relationship Policy Holder:_____
Policy Holder's Address: _____
Policy Holder's Phone: _____

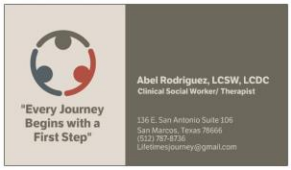
INSURANCE: I may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the times of service and your insurance will be billed for the balance. If I am consider an "out of network therapist" and if you wish to bill your insurance company, I will provide you with a statement at time of services rendered and proper documentation, but I do not or cannot guarantee reimbursement by your insurance company. Due to many insurance variables, when we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. I am providing you with an estimate of your share of the cost treatment as provided to me by your managed care company, insurance company, employee assistance program. Sometimes this information is not consistent with alter information we receive from the insurance company and I have no way of determining that in advance. Your actual share may be more advance that your actual estimate. You are ultimately responsible for the charges incurred as I am not a part of your contact with the insurance company. Remember to please let me know if you change insurance or managed care programs.
MANAGED CARE COMPANIES: Many insurance companies contract with a managed care company to manage the benefits of care. The managed care company may require that I obtain prior authorization for sessions and I usually am required to submit clinical information about you to do so

Fees and/or co-payments vary according to insurance companies. I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of governments benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to Abel Rodriguez, LCSW, LCDC.

_____ _____
Print Name Signature Client/Guardian Date

_____ _____
Signature Therapist Date



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

PURPOSE:

As an independent mental health practitioner, I follow the privacy practice described in this Notice. I keep your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all employees involved in the health care operations of this practice may have access to some of your records.

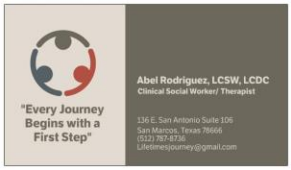
WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS?

Your treatment includes sharing information among health care providers who are involved in your treatment. For example, if you are seeing both a physician or psychiatrist and a psychotherapist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed towards assuring the quality of care.

HOW WILL THIS PRACTICE USE MY PROTECTED HEALTH INFORMATION?

Your personal mental health record will be retained by me for approximately ten years after your last clinical contact; or, in the case of a child, for ten years after the 18th birthday. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy. Until the record have been destroyed, they may be used, unless you ask for and agree to restrictions on a specific use or disclosure for purposes of treatment, payment or other health care operations including, but not limited to:

- Appointment reminders;
- Notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law); administration and management of this practice;
- Mental health oversight activities (e.g., audits, inspections, or investigations of administration and management of this practice);
- For billing and collections;
- Lawsuits and disputes (I will attempt to provide you advance notice of subpoena before disclosing information from your record);
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about a victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the premises; when emergency circumstances occur relating to a crime;



• To prevent a serious threat to health or safety;
• To carry out treatment and health care operations functions through medical transcription services;
• To military command authorities if you are a member of the armed forces or a member of a foreign military authority;
• National security and intelligence activities;
• Protection of the President or other authorized persons or foreign heads of state, or to conduct special investigations;
• Alcohol and drug abuse information has special privacy protections.

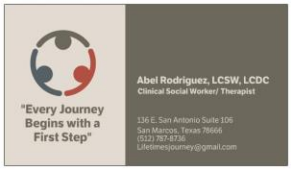
I will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse treatment unless: (i) the client consents in writing; (ii) a court order requires the disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES.

Except as described previously, I will not use or disclose information from your record, unless you authorize (permit) it in writing for me to do so. You may revoke your permission, which will be effective only after the dates of your written revocation.

YOUR RIGHTS REGARDING YOUR MEDICAL HEALTH INFORMATION: Although your health record is the property of the entity that created it, you have the right to:

- Request a restriction, in writing, on certain uses or disclosures of your medical information for treatment, payment, or health care operations, with the exception of emergency operations. Abel Rodriguez, LCSW, LCDC will consider your request but are not legally required to agree to a requested restriction. I will inform you of my decision on your request.
- Obtain a paper copy of this notice of our privacy practices upon request.
- Inspect and obtain a copy of your medical information, in most cases.
- Due to our collaborative relationship and the nature of psychological , your therapist will sch
- Request in writing, an amendment to your records if you believe the information in your record is incorrect or important information was not created by me, maintained by me, or if I determined the record is accurate. You may appeal in writing our decision to not amend a record.
- Obtain an accounting of disclosure stating who and where your health information has been disclosed for purposes other than treatment, payment, health care operations (TPO) or where you specifically authorized a use or disclosure in the past (6) years, but not prior to September 1, 2015. The request must be in writing and state the time period desired for the accounting. After the first request, there may be a charge.
- Request that medical information about you be communicated to you in a confidential way or at an alternative location, but you must specify how or where you wish to be contacted.



REQUIREMENTS REGARDING THIS NOTICE.

I am required to provide you with this notice that governs my privacy practices. I may change policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information I have about you as well as any information I receive in the future. Any time you come in for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me, the appropriate state regulatory agency (see the list below) or the Secretary of the U.S. Department of Health and Human Service. You will not be penalized or retaliated against in any way for making a complaint.

CONTACT: CALL THIS OFFICE IF:

- You have a complaint;
- You have any questions about this notice;
- You wish to request restrictions on uses or disclosures for health care treatment or operations; or
- You wish to obtain additional information or forms to exercise your individual rights described above

STATE REGULATORY AGENCIES:

- For psychologist: Texas State Board of Examiners of Psychologist (512-305-7700).
- For social workers: Texas State Board of Social Worker Examiners (800-232-3162).
- For licensed professional counselors: Texas State Board of Examiners of Professional Counselors (512-834-6658).
- For marriage and family therapists: Texas State Board of Examiners of Marriage and Family Therapists (800-942-3162)

By signing this form, I am consenting for Abel Rodriguez, LCSW, LCDC to use and disclose my medical information as disclosed in this Privacy Information Document.

_____ _____

Signature Client/Guardian Date

_____ _____

Signature Therapist Date