WAYPOINTS
COUNSELING, PLLC

812 W. 8th Street, Suite 6A • Plainview, Texas 79072 • 806-429-8088 • www.waypointscounselingpllc.com

## Client Information

Name:_____ Nickname:_____ DOB: _____

Gender: ☐ Male ☐ Female Home Phone:_____ Cell Phone:_____ Email: _____

May we: ☐Leave a voicemail? ☐ Text Message? ☐Email? (Email communication is a non-secure form of communication; we will not disclose names or identifying information.)

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Relationship Status: _____

In case of an emergency, whom should we contact? Name/Relationship:_____ Phone number: _____

Have you ever been treated by a therapist, counselor, psychologist or psychiatrist? ☐Yes ☐No Provider(s) and approximate dates:

_____

Briefly state your current need for counseling. _____

## Medical Information

Primary Care Physician: _____

Are you currently taking any regularly prescribed medications? ☐Yes ☐No If yes, who is the Prescriber? _____

Please list the medications/dosages below:

Medication Name: _____ Dose:_____Frequency:_____
Medication Name: _____ Dose:_____ Frequency:_____
Medication Name: _____ Dose:_____ Frequency:_____
Medication Name: _____ Dose:_____ Frequency:_____

## Parent/Legal Guardian (if applicable)

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Relationship: _____ Home Phone:_____ Cell Phone:_____ Email: _____

May we: ☐Leave a voicemail? ☐ Text Message? ☐Email? (Email communication is a non-secure form of communication; we will not disclose names or identifying information.)

Street Address: _____

City: _____ State: _____ Zip: _____ SS#:_____

## Spouse/Partner (if applicable)

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Married: ☐ Yes ☐ No Home Phone:_____ Cell Phone:_____ Email: _____

May we: ☐Leave a voicemail? ☐ Text Message? ☐Email? (Email communication is a non-secure form of communication; we will not disclose names or identifying information.)

Street Address: _____

City: _____ State: _____ Zip: _____ SS#:_____

Others living in your household?

Name: _____ DOB: _____ Relationship:_____
Name: _____ DOB: _____ Relationship:_____
Name: _____ DOB: _____ Relationship:_____
Name: _____ DOB: _____ Relationship:_____
Name: _____ DOB: _____ Relationship:_____

By whom were you referred to this practice? _____ May we thank them for the referral? ☐Yes ☐No

Would you like to receive email reminders for your appointments? ☐Yes ☐No

Would you like to receive text message reminders for your appointments? ☐Yes ☐No

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**Explanation of Client Rights**

You have the right:

- To be free from discrimination due to race, religion, gender, sexual or political orientation, disability or any other unlawful category while receiving services
- To be free of exploitation for your benefit or advantage of a clinician
- To expect that your clinician has met the minimal qualifications of training and experience required by state law
- To be informed of the cost of professional services before receiving the services ($145/$120 intake/subsequent sessions)
- To receive information regarding the Limits of Confidentiality before beginning treatment
- To be informed of how your personal healthcare information will be shared with and utilized by any third party
- To obtain a copy of your mental health records as requested. A charge for copies/mailing may be applied ($15.00/fee + $0.20/page)
- To revoke a signed disclosure in writing to your clinician
- To report complaints to the Texas State Board of Social Worker Examiners
- To privacy as defined by NASW ethics and the law
- To request and receive a referral for any needed supplementary services
- To terminate treatment upon request.

Additional information regarding your rights are included in the Clinic Policies and Procedures and the Privacy Notice. By signing this form, I acknowledge that I have read and understand Client Rights and have been given a copy of the Clinic Policies and Procedures and the Privacy Notice.

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Name

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Name

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**Consent to Release Information to Insurance Companies**

I request the payment of authorized benefits be made on my behalf to *Waypoints Counseling, PLLC*, for any services furnished by my mental health provider. I authorize my mental health provider to release to my insurance company and its agents via direct mail, telephone, fax or electronic submission, information about me or my child(ren), and my treatment in order to determine the benefits payable for related services. **I recognize that insurance benefits are limited, and I am financially responsible for non-covered expenses,** and that a psychological diagnosis must accompany requests for payable benefits. I also understand that insurance companies often request additional information as claims are processed.

Signed: _____ Date: _____

**Please provide a copy of your insurance card.**

Name of Insurance Company: _____

Insurance Company Phone Number:_____

ID#: _____ Group #_____ Co-pay Amount:_$_____

Name of Primary Subscriber (PS):_____

DOB of PS: _____ Phone number of PS: _____

Address of PS: _____

Relationship of PS to Client: _____

Does your policy require preauthorization? □ Yes □No

Did you contact your insurance company prior to today's visit? □Yes □No

Do you have additional insurance coverage? □Yes □No (If yes, please complete information below.)

Name of Insurance Company: _____

Insurance Company Phone Number:_____

ID#: _____ Group #_____ Co-pay Amount:_$_____

Name of Primary Subscriber (PS):_____

DOB of PS: _____ Phone number of PS: _____

Address of PS: _____

Relationship of PS to Client: _____

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# Clinic Policies and Procedures

**Appointments**

- We respect your time and we will endeavor to always be on time to allow for your full allotted appointment time. We ask that you respect your clinician's professional time as well.
- **Cancellation Policy:** Please provide **24-hours advance notice** for cancellations or changes to appointments.
  - Appointments that are **not** cancelled with 24-hours advance notice will be charged $60.
  - *Late cancellation fees, missed appointment fees, and other applicable fees (i.e. court appearance fee, requests for paperwork, telephone calls, etc.) will either be invoiced to you or charged to your credit card/debit card on file at the time the service is delivered.*
  - After two missed appointments without cancellations, all future appointments will be cancelled.

**Fees/Insurance Claims**

- The out-of-pocket fee for the intake session (90 minutes) is $145. This fee must be paid *at the time of service*, unless your insurance is accepted at this clinic. Payment methods accepted include cash, check, credit/debit card.
- The out-of-pocket fee for ongoing services is $120 per 60-minute session. This fee must be paid *at the time of service*, unless your insurance is accepted at this clinic. Payment methods accepted include cash, check, credit/debit card.
- A $25 fee and/or any fees applied by the bank for a returned check will be applied.
- Co-pays (if applicable) are due *at the time of service* and can be made through cash, check and credit/debit card.
- If you cannot afford the fees for service, do not have insurance, or elect not to use your insurance benefit, you may apply for a sliding fee scale.
- The clinic will submit claims to your insurance company (if applicable), and you are responsible for any unpaid balance that may be due. You are strongly encouraged to contact your insurance company prior to beginning services to verify information about your benefits.
- If your clinician is not contracted with your insurance company or is not an eligible provider, you will be responsible for payment at the time of service. At your request, a superbill can be provided to you to submit to your insurance for possible reimbursement.
- You should notify the clinic in writing of any changes of insurance, telephone numbers or addresses during the course of treatment and provide a copy of the new insurance card and information.
- If it is necessary to use a collection service or small claims court to receive payment from you, you will be assessed the amount owed to the clinic plus the amount charged by the collection service or court process.
- Requests for paperwork to be completed by the clinician (i.e. FMLA, disability, written letters) will be charged at the clinician's hourly rates.

**Telephone/Out of Office Meetings**

- If you want to discuss an issue over the phone with your clinician, telephone consultations are available. If a phone consultation lasts more than 15 minutes, there is a minimum fee of ¼ of the session fee ($30). If the call lasts 30 minutes or longer, you will be billed at a rate of ¼ of the session fee per 15-minute increment.
- If you need your clinician to meet, speak with, or communicate in any way with any other person including but not limited to an attorney, school, probation officer, CPS worker, or physician, you will be billed for the clinician's time in the same manner as above.
- Your clinician will make reasonable effort to return calls within 24 hours with the exception of weekends, holidays and vacations.

**Emergencies**

- **In the case of an emergency, please contact either 911, go to your local Emergency Room, or contact Central Plains Center Crisis Hotline (1-800-687-1300).**
- Medical and/or psychiatric emergencies should be directed to 911 or the Emergency Room if life or safety is threatened. If you would like to speak to your clinician about your emergency, please leave a message. The

clinician will return your call *as soon as possible during regular working hours*. However, if this is a life-threatening emergency, do not wait for your clinician to return your call.

**Confidentiality**

- You have the right to confidential mental health care *except* in the following cases in which immediate action may be taken:
  - if you pose serious physical danger to yourself or another person.
  - if you disclose that you or another person has physically/sexually/emotionally abused a child, incompetent, disabled or elderly person.
  - if you disclose that a child, incompetent, disabled or elderly person is suffering from abuse, neglect or exploitation.
  - if you disclose that you have committed a crime.
  - defense of claims brought by a client against your clinician or Waypoints Counseling, PLLC.
  - reporting to relevant agencies such as court and insurance companies as may be ordered by the court system or for third party payment.
- Federal law requires that your protected health information (PHI) is managed in specific ways. Our in-house procedures conform to these requirements. However, your use of email and/or phone poses a very low risk of your PHI being accessed by a third party. If you choose to communicate with this clinic by phone and/or email, you are indicating that you accept this risk.
- Posting on social media and rating websites, e.g. Google, Facebook, Instagram, etc., about your experience with your clinician at Waypoints Counseling, PLLC, may reveal yourself as a client, which releases PHI. If you choose to post on social media, you accept full responsibility for releasing your PHI.
- Audio and/or video recording by either the client or clinician is expressly prohibited without written consent. **BY SIGNING THE CONSENT TO TREATMENT STATEMENT, YOU AGREE THAT YOU WILL NOT RECORD.**
- Any suspected violations of clinician ethics may be reported to: Texas Behavioral Health Executive Council, Attn: Enforcement Division, 333 Guadalupe St., Suite 3-900, Austin, Texas 78701. The form to submit a complaint may be found at https://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf. There will be no retaliation against you for filing a complaint.

**Court Appearance Policy**

- If your clinician is subpoenaed to court or requested by you to schedule your clinician's appearance, you will be charged a non-refundable fee of $500, payable in advance, regardless of whether the clinician actually testifies or appears in court. The first $500 applies to a minimum of one day set aside for the clinician to be on call for a court appearance. Expenses the clinician may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at the standard hourly rate and are in addition to the $500 fee. If the clinician is required to be on call beyond the first day for a court appearance, an additional $500 fee will be incurred, for each additional day.

**Other**

- Waypoints Counseling, PLLC does not engage in custody issues or assess for custody placement.

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Name

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**Consent for Evaluation and Treatment**

I, _____, have read, fully understand, and agree to this disclosure and confidentiality statements, and the policies stated in the Notice of Privacy Policies and Procedures. I will be provided a copy of these Policies and Procedures at my request. I authorize Waypoints Counseling, PLLC, to assess and provide mental health services for me and/or my child(ren). This consent is not a contract for treatment. This consent is not an agreement to provide mental health services to you or your family. This consent authorizes the *mental health provider* to perform an assessment of mental health needs, and to determine what services may be needed. This consent may be revoked at any time by the undersigned.

*Parental Consent must be given by a legal guardian with rights of decision-making authority for clients under the age of 18. If the right for decision-making authority for mental health treatment has been altered by court-ordered custody arrangements, a copy of the court order must be provided prior to services.*

*For Parents/Guardians who share custody: It is your responsibility to ensure that you are complying with the custody orders that are in place regarding authorizing psychotherapeutic services for your minor child. It is the custodial parent's responsibility to inform the non-custodial parent that the minor child is receiving psychotherapeutic services, and to make available the contact information for Waypoints Counseling, PLLC.*

Fees for mental health services are based on maximum allowed charges. Every attempt will be made to bill insurance companies for the services provided. **The undersigned agrees to provide accurate and up-to-date insurance information, determine the need for preauthorization for services and determine if the provider is "in or out-of-network." Furthermore, the undersigned agrees to pay all applicable deductible and co-payment fees.**

Erin E. Evanson-Lass is a Licensed Clinical Social Worker (LCSW). She has earned her Master Social Work Degree from Washburn University. Erin E. Evanson-Lass has completed her post-graduate supervised work in order to attain her clinical licensure to practice Clinical Social Work. Erin E. Evanson-Lass is not a psychiatrist and is unable to prescribe medications. If this is of interest to you, you may either contact your physician/licensed psychiatrist, or an appropriate referral can be made.

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Name

_____ _____

Client/Parent/Guardian Signature Date

_____

Printed Name

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## Consent to Release Confidential Records and Information

DATE _____ SSN _____

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ DOB _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

**This release authorizes Waypoints Counseling, PLLC to (check one or both) □release records to: □obtain records from:**

NAME OF PERSON/PROFESSIONAL/AGENCY/FACILITY _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ FAX NUMBER _____ EMAIL _____

□ Verbal Communication □ Fax □ Email Communication (email is a non-secure form of communication)

**Release the Following Records (charges may apply if for personal, not professional release):**
□ Progress Notes □Intake Records □Discharge Summary
□ Diagnosis and Treatment Plan □Other:_____

**The purpose/need for this disclosure is:**
□ Care Coordination □Other:_____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:
□ Do not release HIV-related information. □ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after **one year** from the date on which it is signed.
**By signing this form, I attest that I understand and agree with the content of this form.**

_____ _____
Client Signature (18 and older) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Clinician Signature Date

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## Credit Card Authorization Form

Please note that this form will be securely stored in a HIPAA compliant, secure location in your clinical file and that you are willing to assume the risk for keeping this information on file. This form will be shredded at the termination of therapy services.

I authorize Waypoints Counseling, PLLC to keep my signature and credit/debit/flex spending account card information as filled out below on file and to charge my card for therapy session fees (individual, groups, workshops, couples, family, telephone sessions, or other), late cancellation fees, missed appointment fees, fees associated with requests for paperwork, and court appearance fees in accordance with services provided to the client.

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services will normally be posted to my credit/debit/flex card account within 72 hours of each session date and my session fee will be charged immediately following the session. Additionally, I agree that the card listed below may be charged by Waypoints Counseling, PLLC in order to settle any outstanding balances accrued by the client listed above upon termination of therapy services including any materials (i.e. books, cds, dvds) that I have not returned within one week of termination. I understand that if a charge back fee is incurred, I am responsible for that fee. **Initial_____**

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Waypoints Counseling, PLLC for any assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Waypoints Counseling, PLLC and those attempts have failed. **Initial_____**

Further, if I am assuming session payment responsibility for the client and that client is someone other than me, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Waypoints Counseling, PLLC. **Initial _____**

I understand that I will be charged via this form and not by swiping my card to collect fees for therapy services rendered, late cancellation fees, missed appointment fees, telephone services, court appearance fees or requests for paperwork. **Initial _____**

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above.

Signature_____ Print Name_____

CARD TYPE (circle one): VISA MASTERCARD DISCOVER AMERICAN EXPRESS HSA

CARDHOLDER FIRST NAME (as it appears on the card) | MIDDLE NAME | LAST NAME

CARD NUMBER | EXPIRATION DATE | SECURITY CODE (3digit code on back or 4 digit code on front of AmEx)

BILLING STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMAIL

CARDHOLDER SIGNATURE | DATE

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**PRIVACY NOTICE**

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

I. Uses and Disclosures for Treatment, Payment and Health Care Operations: Clinicians and office staff may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:
   a. PHI refers to information in your health record that could identify you specifically.
   b. Treatment is when clinicians provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be therapy, or when a therapist consults with another health care provider, such as your family physician or another clinician.
   c. Payment is when a clinician obtains reimbursement for your health care. Examples of payment are when your clinician discloses your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
   d. Health Care Operations are activities that relate to the performance and operations of a clinician's practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
   e. Use applies to activities within your clinician's office such as sharing, employing, utilizing, examining, and analyzing information that identifies you.
   f. Disclosure applies to activities outside your clinician's office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization:
   a. Clinicians may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. When a clinician is asked for information outside of treatment, payment, or health care operations, an authorization will be obtained from you before releasing this information.
   b. Clinicians will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapist notes are notes your clinician has made about conversations during an individual session, joint marital, or family therapy sessions, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
   c. You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1). Your clinician has relied on that authorization or 2). If the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Requiring Neither Consent Nor Authorization:
   a. Child Abuse: If there is reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect, or sexual abuse, clinicians must report the matter to the appropriate authorities as required by law.
   b. Adult and Domestic Abuse: If there is reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, clinicians must report this belief to the appropriate authorities as required by law.
   c. Health Oversight Activities: Clinicians may disclose PHI to the Texas Board of Social Work Examiners if necessary for a proceeding before the board.
   d. Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services provided you and/or the records thereof, such information is privileged under state law, and information will not be released without authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
   e. Serious Threat to Health or Safety: If your clinician believes there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in foreseeable future, information may be disclosed in order to protect that individual.
   f. If your clinician believes that you present an imminent risk or serious physical harm or death to yourself, information may be disclosed in order to initiate hospitalization or to family members, or others who might be able to protect you.
   g. Felony Reporting: You clinician may be required or allowed to report any felony that you report to your clinician that has been or is being committed.
   h. Required by Law: Your clinician will disclose health information about you when required to do so by federal, state, or local law.
   i. Law Enforcement: Your clinician may release health information about you when asked to do so by law enforcement officials in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal process.
   j. Worker's Compensation: Your clinician may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs, established by law that provide benefits for work-related injuries or illness without regard to fault.
   k. Prenatal Exposure to Controlled Substances: Mental health providers are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
   l. Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
   m. Insurance Providers (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of services, dates/times of services, diagnosis, treatment plan, description of symptoms, progress of therapy, case notes and summaries.

IV. Client's Rights

a. You have the right to request restrictions on certain uses and disclosures of PHI about you for treatment, payment, or health care operations. However, your clinician is not required to agree to a restriction you request, except under certain limited circumstances, and your clinician will notify you in that case. One right you may not be denied is your right to request that no information be sent to your health care plan if you pay in full for the health care plan services ahead of time. If you select this option, then you must request it and must pay in full each time a services will be provided. Your clinician will not send any information to the health care plan for that session unless your clinician is required by law to release the information.
b. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
c. You have the right to inspect and copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. This does not apply to information created for use in a civil, criminal, or administrative action or proceeding. You may be charged a reasonable fee for copies, mailing, or associated supplies ($15.00 fee + $0.20 per page). Your access to PHI under certain circumstances may be denied, but some cases you may have this decision reviewed. On your request, your clinician will discuss with you the details of the request and denial process.
d. You have the right to request an amendment of PHI as long as the PHI is maintained in the record. Clinicians may deny your request. On your request, your clinician will discuss with you the details of the amendment process.
e. With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI. On your request, your clinician will discuss with you the details of the accounting process.
f. You have the right to obtain a paper copy of this privacy form from your clinician upon request, even if you have agreed to receive the notice electronically.

V. Clinician's Duties
a. Clinicians are required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
b. Clinicians reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, your clinician will abide by the terms currently in effect.
c. If these policies and procedures are revised, you will receive written notification in person or by mail.
d. In the event that your clinician learns that there has been an impermissible use or disclosure of your unsecure PHI, unless there is a low risk that your unsecured PHI has been compromised, you will be notified of this breach.

VI. Technology, Privacy and PHI
a. Email: Internet communication, including email, is a non-secure form of communication. If you elect to use Internet communication with your clinician, this practice will make every effort not to disclose names or other identifying information (PHI) in the course of this communication, as should you attempt not to include identifying information.
b. Texting: Texting communication is a non-secure form of communication and should be limited to conversations about scheduling only between the hours of 9:00am-7:00pm.
c. Social Media: No contact via social media is allowed with your clinician, as this is a non-secure form of communication and violates ethical boundaries. This includes but is not limited to Facebook, Twitter, Instagram, snapchat, Pinterest, and LinkedIn.
**d.** The subject matter of Internet communication and texting should be limited to scheduling conversations only and limited between the hours of 9:00am – 5:00pm. **In the case of an emergency, please contact either 911, go to your local Emergency Room, or contact Central Plains Center Crisis Hotline (1-800-687-1300).**

VII. Complaints
a. If you are concerned that your rights have been violated or you disagree with a decision made about access to your records, you may contact Waypoints Counseling, PLLC and it will be considered how best to resolve your complaint. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington D.C. or to:

**HHSC Civil Rights Office**
Health and Human Services Commission
701 W. 51st Street, MC W206
Austin, Texas 78751
Phone: 1-888-388-6332 or (512) 438-4313
Fax: (512) 438-5885

There will be no retaliation against you for filing a complaint.

VIII. Effective Dates
a. This notice goes into effect immediately, the policies and procedures detailed herein having been implemented prior to this notice. In the event of any revisions, a notice will be mailed to you.

IX. Privacy and Security Officer
a. Erin E. Evanson-Lass, LCSW acts as the Privacy and Security Officer for Waypoints Counseling, PLLC. Contact information is listed at the beginning of this form.