Rio Grande Counseling Center

Diana Garza Louis, LPC-S, LMFT-S, RPT-S
314 Highland Mall Blvd. Suite 252
Austin, TX78752
512-560-7196
dgarzalouis@gmail.com
www.RioGrandeCounselingCenter.com

Welcome to Rio Grande Counseling Center

Professional Disclosure Statement for Diana Garza Louis

1. Qualifications and Experience:

My name is Diana Garza Louis, and I received her Master's in Education in Counseling and Guidance at Texas State University in San Marcos, Texas in 1983. I received my Bachelor of Arts in Psychology from the University of Texas, and attended the University of the Americas in Puebla, Mexico for most of my undergraduate studies. I am a License Professional Counselor, Marriage and Family Therapist, Registered Play Therapist and National Certified Counselor. I started my career in inpatient settings (hospitals and residential treatment centers) and started my private practice in 1984. I specialize in working with children and families, Play Therapy, Spanish speaking clients, and sexual abuse treatment for victims, and children with sexual behavior problems. I received my supervisor status for Professional Counselors and Marriage and Family Therapists and supervise candidates for these licensures since 1997 and I am also a supervisor for candidates for Registered Play Therapists. I am also EMDR certified and a Certified Culturally Competent therapist by Our Lady of the Lake University.

2. Theoretical Perspective

My approach is multi-modal and integrative, mostly using Person Centered, Systems, Cognitive Behavioral, Emotionally Focused, Trauma Focused, and Therapeutic Alliance models. With children my focus is Child Centered Play Therapy using directive and non-directive models to address the child´s needs. Using different modalities of treatments helps me focus on the patient and their needs, allowing me to be present and understanding of the impact systems has in the patient's environment. In therapy, we address behavioral change, increase coping skills, attend to past trauma. Improving quality of life and relational connections are part of meeting therapeutic goals. I advocate for a respectful and culturally sensitive therapeutic relationship.

3. Length of treatment

Short term counseling sessions are suggested and re-assessed at 6 session intervals. Patients may be referred as needed for long term treatment or specific treatment needs.

Immigration Evaluations are usually scheduled for three one-hour sessions. The therapist will conduct an interview, ask the patient to fill out some questionnaires, review those responses, and write a letter of support usually within 10 days after the last session.

4. **Legal and Ethical Considerations:**

Patients are encouraged to express any concerns regarding their therapeutic treatment so that any discomfort or disagreement may be resolved in an appropriate manner. If the patient is dissatisfied with their services, referrals will be made with someone who might meet their needs more appropriately.

If the patient feels they have not resolved their concerns with the therapist directly or with Ms. Diana Garza Louis as the director of Rio Grande Counseling Center and feels therapist assigned to them has been abusive, negligent or has committed an ethical breach, they may file a complaint with the following state board.

Texas Behavioral Health Executive Council
1801 Congress Ave., Ste. 7.300
www.bhec.texas.gov

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TREATMENT AGREEMENT

Please initial on the left to indicate you have read and understand each paragraph.

_____ **Psychotherapy** is not an exact science, and so, there are no guarantees made as to the results of such a service. In treatment you may expect to review and discuss issues which are causing distress or discomfort to you or your family and ways of dealing with these issues. Solutions are explored, but may not always be attainable.

_____ **Participation Agreement:** I (or my child) agree to participate in the assessment and treatment provided by Rio Grande Counseling Center and follow recommendations and assignments given as part of my treatment. I understand that my participation in treatment is voluntary, although I may be referred by an agency that requires that I participate in this program. I understand that if I have been court ordered to treatment, I can refuse this treatment at any time and consult with the agency that has referred me. I understand that I may be referred to another resource for services that are not available at this center or to services that might better suit my needs.

_____ **Confidentiality:** I understand that confidentiality is limited in all cases of child abuse in accordance with the Texas Family Code and all child abuse must be reported to the appropriate authorities. I further understand that if I am a danger to myself or others, my therapist must report this to the proper authorities or refer me for specialized treatment for my condition. I understand that Private Health Information (PHI) can be shared with other parties in case of billing insurance or other parties, court proceedings or if I have a case with Child Protective Services.

Parents often want to know the status of their chld's treatment and progress. To promote the child's trust and sense of confidentiality, the therapist may not share the actual conversations that they had with the child, but a summary of their session or the therapist's opinions and suggestions will be shared. Parents may be asked to have a parent consultation session periodically, separate from the child's session to review and discuss the child's progress.

_____ **Communication:** I agree to have communication with my therapist by:

(please indicate your contact information for each medium).

□ Phone: _____

□ Text: _____

□ Email _____

_____ **I have received information regarding my rights for privacy of health al information as per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand I have the right to request copies of my records with a written request, but that my therapist is not obligated to providing case notes as part of this request. A summary of services may be provided in lieu of original records.**

_____If I encounter anyone at this center who is familiar to me, I agree to maintain confidentiality and not disclose this information to anyone to respect their privacy, as I would like them to respect mine.

_____**Cancellations:** I agree to come to scheduled appointments or call in advance to cancel my appointment. I understand that I **will be charged the full fee** if I do not call to cancel 24 hrs. in advance.

_____ **Court Proceedings:** I understand that if my case requires any services due to court proceedings, including contact with collateral parties/attorneys, etc., review or copies of records, depositions, preparation for court, court appearance or any other related services, I will be asked to provide a retainer to cover the costs of these services.

_____ **Divorce Decree:** I understand that if I am separated or divorced, and my child is receiving services from Rio Grande Counseling Center, I am required to provide a copy of my divorce decree and any current visitation and custodial agreements/orders regarding my child.

_____ **Control and Custody of Client Records:** The Texas Behavioral Health Executive Council requires information regarding the control and custody of client records. In the event that client records are in the control or custody of Rio Grande Counseling Center, and Ms. Garza-Louis is deceased, incapacitated or terminates her practice, information regarding request for records will be posted on the Rio Grande Counseling Center internet site at http://www.RioGrandeCounselingCenter.com.

Fees: Payment is expected at the time of service. The following fees will be charged for services:

	$125.00/hr.
Initial Evaluation/ Intake	$125.00/hr.
Individual or Family Therapy	$50.00/ group
Group Therapy	$200.00 /hr.
Court Testimony (Calls, records, preparation)	$125.00 - $1,875.00
Immigration Evaluation	$700.00 - 3 ssessions and support letter (Plus $125/hr. as needed)

Please initial the one that applies to you.

_____ Fees will be paid by me.

_____ I have been approved for Victim's Compensation. My number is # _____

_____ Fees will be paid by Contract with an agency

_____**Consultation:** I give my consent for the therapist involved in my case to consult with other staff at Rio Grande Counseling Center regarding my case to assist in treatment planning and service delivery. I also understand that my therapist may review my case with their supervisor or an outside consultant to assist in treatment planning. I understand that any consultation outside of the center will be done in a confidential manner and not provide any information regarding my identity.

Consent for release of audio, video and written work: I give my consent for Rio Grande Counseling Center to display work products from my treatment such as artwork, video, audio, written or other forms of media as samples of my work in treatment. These products may be displayed in various media such as internet websites, newsletters, slides in training or other mediums of display to other professionals in training for mental health services.

I understand all products of my work will be de-identified and will be maintained anonymous.

_____ **Yes.** I give my consent for the release of audio, video, art, and written work.

_____ **No.** I do not give my consent for the release of audio, video, art, and written work.

Complaints: I understand that if I am dissatisfied with my services and if I instigate legal action against Rio Grande Counseling Center, its agents, contract therapists, interns, trainees or employees, and they prevail in such action, I hereby agree to pay all costs involved in defending such legal action, including, but not limited to reasonable attorney fees, time away from work, cancelled clinical hours, and travel expenses.

If I feel the therapist assigned to me has been abusive, negligent or has committed an ethical breach, I may file a complaint with the following state board:

Texas Behavioral Health Executive Council
1801 Congress Ave., Ste. 7.300
Austin, Texas 78701
www.bhec.texas.gov

Client Name _____ Date_____

Client Signature _____ Date _____

Therapist Signature _____

Good Faith Estimate
(No surprises Act)

You have the right, under the law, to receive a Good Faith Estimate explaining how much your counseling services will cost.

Diana Garza Louis is not a provider for insurance, therefore this is a Good Faith Estimate regarding the cost of the non-emergency services you will receive at Rio Grande Counseling Center.

If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill.

Save a copy or picture of this Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises .

Date of Good Faith Estimate: _____

The estimate below is the average cost that is likely for most new patients. I suggest we meet for six sessions to start your treatment. We will review and decide if you should continue treatment after the fifth session and estimate how much longer we should continue your treatment. My fee for psychotherapy services is $125.00 per hour. We will decide within the first two sessions if we should meet weekly, twice a month or monthly. These estimates are **costs per child.**

Service	CPT code	Cost
Initial evaluation $125.00 per hour	Initial evaluation 90791	$125.00
Additional psychotherapy sessions (five) $125.00 per hour	Individual therapy 90837 or Family therapy 90847	$625.00
Total for six sessions at $125.00 per hour		$750.00

If we decide to continue your treatment you will be billed at $125.00 per hour.

Here is a list of other services that I provide and the cost for those services. We will discuss your needs and I will provide an estimate if you should need any of these additional services.

Service	Cost
Group Therapy	$50.00 per hour
Court Testimony Calls, records, preparation	$200.00 per hour
Retainer in case of court involvement	$625.00 as needed
Assessment/Testing up to 12 hours	$125.00 – $1,875.00

If you have questions about this estimate, please contact me at dglouis@gmail.com or 512-560-7196.

NPI number: 1124026364 EIN: 452335691

Client signature _____ Date: _____

Therapist Signature _____

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Technology Assisted Psychotherapy

The purpose of this document is to inform you, about different aspects of online counseling services and the risks and benefits, safeguards, and alternatives to these services.

Technology Assisted Psychotherapy in the state of Texas (USA), is governed by the laws of the state. Clinicians will operate under the same ethical standards of professionals whether conducting therapy online or in person. State regulations require clinicians to provide services in a state in which they hold a current and valid license. Clinicians at the Rio Grande Counseling Center have complied with the required hours of technology-assisted training.

Technology Assisted Psychotherapy is provided via telephone or video conferencing to facilitate contacts between the patient and the therapist. Telephone and video conferencing may be used to provide Technology Assisted Psychotherapy including individual and group psychotherapy.

Technology Assisted Psychotherapy will be provided by third party program application services such as the Site 5 website, Google Suite (Google Meet), Zoom, WhatsApp, Facebook Messenger, Skype, and other services. These services are HIPAA* compliant modes of communication that include SSL (Secure Sockets Layer) and encryption provided by third party services to assist in HIPPA compliance to maintain confidentiality of information exchange.

Potential risks in the use of Technology Assisted Psychotherapy may include difficulty with communication due to unreliable or failure of technology, security or privacy breaches due to unforeseen and unknown hacking or other technology invasion out of the control of the treatment provider, difficulty navigating using the technology and difficulty for the treatment provider in "reading" expressions or other visual cues that may indicate discomfort or other non-verbal gestures.

To ensure services are provided to the appropriate patient, the patient will provide identification such as a picture ID with their name and address.

The service provider will provide the patient with a copy of a professional license credential to ensure the client of their professional status.

Advantages of Technology Assisted Psychotherapy include convenience in scheduling appointments with less travel and time constrains and the convenience of in-home services for the patient and the therapist.

In case of failure of technology, the patient and therapist will attempt the following steps:

1) Disconnect and re-connect using the same program application.
2) Disconnect and change to another program application mutually agreeable to both parties in advance.
3) Re-establish contact by phone at 512-560-7196 or by email at dgarzalouis@gmail.com
4) Re-schedule the appointment.

Diana Garza Louis has complied with the Marriage and Family Therapy license requirement of at least 8 hours of training in technology assisted mental health services. (Rule 801.58 of the Texas Administration code for Licensed Marriage and Family Therapy).

Rio Grande Counseling Center does not collect any personal information or tracking information except for scheduling, billing and providing psychotherapy services. The treatment provider maintains treatment records electronically that are password protected, private, and confidential records. In case the therapist discontinues their practice or in case of death, information regarding transfer of records will be posted on the Rio Grande Counseling Center website at: http://www.riograndecounselingcenter.com.

I, (patient name_____) agree to use Technology Assisted Psychotherapy as an alternative to in-person services and I understand the advantages and disadvantages and risks associated with Technology Assisted Psychotherapy.

_____ _____

Patient signature Date

_____

Printed name

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Child History

Date: _____

Child's Name: _____ DOB: _____

Address: _____Zip: _____Phone: _____

School: _____ Grade: _____

Parent's Names: _____ Phone _____

_____Phone: _____

Where did you hear from our services? Referral or resource name _____

In case of emergency, call _____Phone _____

E-mail mother: _____Work Phone: _____

E-mai father: _____Work Phone: _____

Are parents divorced or separated? ____ Yes ____ No

Custodial Parent ____ Mom ___ Dad

Sibling's Names: _____ Age: _____

_____ Age: _____

_____ Age: _____

Contact with other significant persons? (Grandparents, cousins, etc.) ____ Yes ____ No

Who? _____

Does your child take medications? ____ Yes ____ No What? _____

Is s/he under a doctor's care? ____ Yes ____ No Dr.'s Name: _____

Developmental History (please note any handicaps developmental delays. Include child abuse, domestic violence,

sexual abuse, alcoholism, problems at home or school):

Present family problems:

_____

Problems at school:

_____

Medical Problems:

_____

Hospitalizations:

_____

Do you (parents) or your spouse drink alcohol or use drugs? ____ Yes ____ No

How much do you use/drink in one week? _____

Family Health problems:_____

Emotional/Behavioral Problems:

_____

Relationships with:

Mother: □ Close □ Distant □ Problematic □ Abusive/Physical/Sexual/Emotional

Father: □ Close □ Distant □ Problematic □ Abusive/Physical/Sexual/Emotional

Siblings: □ Close □ Distant □ Problematic □ Abusive/Physical/Sexual/Emotional

Friendships: □ Close □ Distant □ Problematic □ Abusive/Physical/Sexual/Emotional

Others: □ Close □ Distant □ Problematic □ Abusive/Physical/Sexual/Emotional

Please give information regarding Previous Marriages (difficult/friendly divorce, family violence, abuse,
etc.)_____

_____

_____

Behavior at School: _____

_____

Comments/ Concerns: _____

_____

_____

Problems with:

□ Nightmares □ Fighting □ Bed Wetting □ Defiance

□ Drug Abuse □ Sexual Abuse □ Physical Abuse □ Anxiety Depression

□ Other _____

Comments/ Concerns:

_____

_____

What goals do you have for your child's counseling?

_____

_____

_____

Comments:

_____

_____

_____

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CONSENT FOR RELEASE OF INFORMATION

Name: _____ **Date:**_____

Child's name if regarding my child_____

I,_____ authorize Rio Grande Counseling Center, it's agent or representatives, to release information to, or acquire information from:

☐ School: _____

Teacher/Counselor: _____

Phone #: _____

Email: _____

☐ Previous Therapist: _____

Phone #: _____

Email: _____

☐ Physician: _____

Phone #: _____

Email: _____

☐ Psychiatrist: _____

Phone #: _____

Email: _____

☐ Hospital: _____

Phone #: _____

Email: _____

☐ Child Protective Services: _____

Caseworker: _____

Phone #: _____

Email: _____

☐ Court/County District Attorney: _____

Phone #: _____

Email:_____

☐ Attorney:

_____

Phone #: _____

Email:

_____

☐ Other: _____

Phone #: _____

Email:

_____

The purpose of this release to coordinate information and/ or obtain necessary documents. I understand this information will be used in a confidential manner. I also understand that my therapist will abide by all the laws of the State of Texas regarding child abuse and neglect and will report any incidents of child abuse I may disclose. I also understand that any threats of suicide or violence may be reported to appropriate authorities if my therapist deems necessary.

This consent is valid for one year after termination of services unless otherwise revoked.

Comments: _____

_____

_____

_____

_____ _____

Client Signature/Parent or Guardian Date

_____

Child Signature

_____

Therapist

Rio Grande Counseling Center

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Austin, TX 78752
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NOTICE OF THE RIO GRANDE COUNSELING CENTER PRIVACY PRACTICES

The administrators of the Rio Grande Counseling Center (RGCC) know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to the RGCC refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

RGCC may use your health information, for purposes of making or obtaining payment for your care, and for conducting health care operations. The RGCC has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment The RGCC may use or disclose your health information to make payment to or collect payment from third parties, such as health plans, for the care you receive. For example, the RGCC may provide information regarding your coverage or health care treatment to health plans to coordinate payment of benefits.

To safeguard the confidentiality of your health information, you may request that the RGCC communicate in a specified manner or at a specified location. For example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. The RGCC will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, the RGCC may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request. I understand I have the right to request copies of my records with a written request, but that my therapist is not obligated to providing case notes as part of this request. A summary of services may be provided in lieu of original records.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that the RGCC amend the records. That request may be made as long as the information is maintained by RGCC. RGCC may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the RGCC, if the health information you are requesting to amend is not part of the RGCC's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the RGCC determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by RGCC for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The RGCC will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The RGCC will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF THE RGCC

RGCC is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. RGCC is required to abide by the terms of this Notice, which may be amended from time to time. RGCC reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If RGCC changes its policies and procedures, the RGCC will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. **You have the right to express complaints to the RGCC and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.** The RGCC encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

To Conduct Health Care Operations RGCC may use or disclose health information for its own operations to facilitate the administration of RGCC and as necessary to provide coverage and services to all of RGCC's participants. Health care operations include activities such as:

- Case management within the center with staff who are practitioners, interns, employees and other representatives of the center.

- Supervision and review of cases to provide consultation, recommendations and assistance in providing services to individuals.

- Training of professionals and students within the center. In reviewing cases, identifying information is strictly confidential, though case presentations may include general health information.

When Legally Required RGCC will disclose your health information when it is required to do so by any federal, state or local law.

In All Cases of Child Abuse In accordance with the Texas Family Code all child abuse must be reported to the appropriate authorities.

Danger to Self or Others If you or someone known to RGCC staff is in danger of hurting yourself or others, this information must be reported to the proper authorities or refer you for specialized treatment for this condition.

To Conduct Health Oversight Activities RGCC may disclose your health information to a health oversight agency for authorized activities including audits civil administrative or criminal investigations, inspections, licensure or disciplinary action. RGCC, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceeding As permitted or required by state law, RGCC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when RGCC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, RGCC may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if RGCC has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety RGCC may, consistent with applicable law and ethical standards of conduct, disclose your health information if RGCC, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require RGCC to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Worker's Compensation RGCC may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, RGCC will not disclose your health information without your written authorization. If you authorize RGCC to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that RGCC maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on RGCC's disclosure of your health information to someone involved in the payment of your care. However, RGCC is not required to agree to your request.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an RGCC representative at 512-560-7196; 314 E. Highland Mall Blvd. Ste 252; Austin TX 78752, or e mail at dgarzalouis@gmail.com.

EFFECTIVE DATE

This Notice is effective April 14, 2023