

Gisela Lin Counseling and Consultation Services, PLLC  
1401 Sandia Plaza, Suite 1  
Bryan, TX 77802  
DrLinCares@counselingmail.com  
979-314-9698

### Practice Policy for EAP Services

I am Jun-chih Gisela Lin, Ph.D., ABPP, owner psychologist and the provider of Gisela Lin Counseling and Consultation Services PLLC. The following are the practice policies of the practice of Gisela Lin Counseling and Consultation Services, PLLC and Dr. Jun-chih Gisela Lin. Please contact Dr. Lin at any time with questions or concerns regarding these policies.

#### Counseling/Therapy Services:

I, Jun-chih Gisela Lin, Ph.D., ABPP am a licensed psychologist in Texas and a board-certified counseling psychologist. I provide counseling/therapy for adults and adolescents using a wide array of approaches including, but not limited to cognitive behavioral therapy, systemic therapy and relaxation techniques. I use a multicultural counseling framework and take on multiple helping roles when working with my clients. I believe counseling/therapy is a journey and a joint venture that empowers clients to increase their self-efficacy. The primary goal of counseling/therapy is to assist clients in developing effective coping strategies and in improving their overall functioning and problem-solving abilities in multiple areas of their lives. Specific counseling interventions and any possible side effects will be discussed during your sessions. The counseling/therapy duration and frequency will be determined on an individual basis. Progress and results may vary from individual to individual, and no specific result is guaranteed.

You, as a client, have the right to access information contained in your counseling/therapy records, and it will be provided once we have discussed your request and any possible consequences associated with reviewing the material.

#### Confidentiality:

The ethical principles of the American Psychological Association state that “Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal confidential information to others only with the consent of the person or the person’s legal representative, except in those unusual circumstances in which not doing so would result in clear danger to the person or others. Where appropriate, psychologists inform clients of the legal limits of confidentiality.”

Specific exemptions to the requirement of confidentiality include those for threats of suicide, homicide, damage to other’s property, and ongoing cases of abuse of a minor child, elderly, or an incapacitated adult. The law specifically requires that a mental health professional break confidentiality to ensure the safety of the person at risk.

#### Ethics:

I, Jun-chih Gisela Lin, Ph.D., ABPP subscribe to the ethical principles of the American Psychological Association and adhere to all laws regulating the practice of psychology in the state of Texas.

#### Crisis and Emergency:

This practice does not provide 24-hour crisis counseling. You understand that in case of crisis, if you cannot reach Dr. Lin at 979-314-9698, if you live in Brazos County Texas, you can call the MHMR hotline 979-822-6467 or call your local MHMR number, or call 988 Suicide and Crisis Lifeline, or call the National Suicide Prevention Lifeline 1-800-273-TALK (8255). If you have a life-threatening emergency, you should call 911, or go to the nearest hospital emergency room.

#### EAP Services and Fees:

Dr. Lin provides limited EAP (Employment Assistant Program) counseling services via Telehealth through ComPsych and other insurance companies if she is in network with them and if she has availability. You do not have copay for the EAP sessions as part of benefits through your employer, but these EAP sessions have number limits and an expiration date. EAP also expects their EAP provider meets with you within a few days once an assigned referral is received. Dr. Lin may decline a referral if she does not have availability. It is your responsibility to notify your EAP to assign the authorization to Dr. Lin.

Dr. Lin's EAP sessions are through Telehealth only. She believes not all clients can best benefit from counseling through Telehealth modality as some clients may be better served through in person meetings. Therefore, Dr. Lin may offer you, a potential client, a free initial short phone consultation before she sets up an initial appointment. The EAP sessions can be transferred to another provider if Dr. Lin is not the best fit.

#### Cancellation or No Show:

Appointments are scheduled individually; with the exception of unforeseen emergencies, cancellations are expected 48 hours in advance. Requests for changing appointment times should be discussed in advance. If an initial appointment is cancelled or if you do not show up for your first appointment, Dr. Lin may not have availability to reschedule. It is your responsibility to contact Dr. Lin to reschedule any missed meeting. If you are an existing current client and if you do not contact Dr. Lin to reschedule within 60 days of a late cancellation or missing appointment, the counseling relationship will be terminated.

#### Confidentiality Agreement:

The following statements explain confidentiality as it applies to discussions between psychologist and client and the limits on the confidentiality of disclosures made to a psychologist by Texas State Law. The information is important to you, so please read it carefully.

#### What Is Protected

In general, your identity as a client, as well as the disclosures that you make to my practice and me (Dr. Jun-chih Gisela Lin) in the course of our work, is private and protected. This means that I do not reveal to others that you are a client of mine, nor do I share anything that you say during our work with anyone else. If you would ever like me to reveal your status as a client, or you would like me to share mental health information, you will be asked to sign an agreement waiving your right to confidentiality. Because certain information that I maintain in your file may need to be interpreted to be properly understood, it is my policy only to release relevant information from files to qualified mental health professionals. In the event that you would like information from your file released to a third party, other than another mental health

professional, my policy is to provide a summary of the treatment information contained in your file. If coordination of care is needed, I may share relevant information with other health or mental health care professionals. I may also consult with other mental health professionals to better serve you without revealing any identifying information. In the event of my unexpected incapacity or death, my designee will help you make a transition to another professional upon request.

#### What Is Not Protected

There are certain situations in which disclosures made to my practice and me cannot be kept strictly private due to state law. These situations include:

If you indicate that you are in serious and immediate risk of harming yourself or someone else, I cannot maintain your privacy. The most typical situation is when the threat of suicide is such that I cannot be assured of your safety once you leave the session. It is important to note that this does not apply to talking about thoughts of harming yourself that you may be experiencing. However, in the event that you intend to act on your thoughts to kill or harm yourself, I am required to act to protect you, even if that involves breaching confidentiality. Life is more important than the right to privacy.

If you indicate that you are involved in the abuse of a minor child, an elderly adult, or a disabled person, I am required to file a report about these activities with the Office of Human Protective Services. Once I file the report, I am unable to safeguard the privacy of the information the Office of Human Protective Services has.

If you are involved in a court proceeding, the court may use the power of subpoena to gain access to information that you have shared with me. Although it is my policy to limit my involvement in legal proceedings as much as possible, under court order, I may be required, by law, to provide written or verbal testimony to the court.

If you indicate that you were sexually violated by another licensed mental health professional in Texas, I am required to report this information to the district attorney in the county in which the incident took place, as well as to the licensing board governing that person's license. Please note: this does not apply to disclosure of sexual misconduct by anyone other than a licensed mental health professional in Texas from whom you were receiving treatment.

If you have a temporary psychosis or are incapacitated, I may share your information with your family, friends, or others involved in your care for coordination of care if I believe doing so is in your best interests.

Be assured that your right to confidentiality is very important to me. It is a rare situation that would require me to breach confidentiality, and I will make every effort to use care and discretion while meeting my legal and ethical obligations.

HIPAA Notice of Privacy Practices:

During or before the first session, Dr. Lin will answer any questions you might have regarding the HIPAA Notice of Privacy Practices. The notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please let Dr. Lin know if you have any questions. By giving consent to therapy and signing the Informed Consent for Treatment and Financial Responsibility Agreement, you acknowledge you have read the Practice Policy of Gisela Lin Counseling and Consultation Services PLLC and Jun-chih Gisela Lin, Ph.D., ABPP.

I have read the Practice Policy of Gisela Lin Counseling and Consultation PLLC and Jun-chih Gisela Lin, Ph.D., ABPP, and I consent to receive treatment for EAP services. Yes \_\_\_ No\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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**Client Information and Concerns Form**

Referral source (who referred you or how did you hear about Dr. Lin) \_\_\_\_\_

Name: \_\_\_\_\_ . Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Email address: \_\_\_\_\_ Permission to email? Yes\_\_ No\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (cell) \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_

Permission to call and leave a message or text? Yes\_\_ No\_\_ Preferred contact number: \_\_\_\_\_

Assigned sex at birth: \_\_\_\_\_ Gender identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Relationship status: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Names and ages of any children: \_\_\_\_\_

Ethnic Identity or Nationality: \_\_\_\_\_ Religion/Spirituality: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently employed? \_\_\_ Where? \_\_\_\_\_

Years of school completed: \_\_\_\_\_ Highest degree conferred: \_\_\_\_\_

If you are a student, please indicate your present academic classification: \_\_\_\_\_

Major: \_\_\_\_\_ GPA: \_\_\_\_\_ Future career goal: \_\_\_\_\_

What special accommodations might you need? \_\_\_\_\_

Parent or Guardian if minor or appointed by court

Name \_\_\_\_\_ Relationship to client \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency contact

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to client \_\_\_\_\_

Address \_\_\_\_\_

Please describe your mental health history of diagnoses or concerns in the past or currently.

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Please describe your family members' mental health history of diagnoses or concerns in the past or currently.

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Please describe your medical history of any medical problems or physical symptoms currently.

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Date of last physical examination: \_\_\_\_\_ Doctor's name \_\_\_\_\_

Please list all medications that you take on a regular basis. Please also list all non-prescription medications, herbs, supplements that you are taking.

Medication Name/Dosage	Condition prescribed/taken for	Prescribing Physician

Please describe any previous counseling or psychiatric treatment (including any behavioral health hospitalization).

When/Duration	Where	Why (What Concern)	With Whom

Please describe the event(s) that occurred recently which influenced your decision to come for counseling at this time. Why now?

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Describe significant life events and any other relevant history about the events that occurred.

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How long have you been affected by this concern/issue (week, month, year, etc.), and describe what and how your concerns/issues interfere with your quality of life, relationships, work, school.

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What have you already tried to do about your concerns/issues?

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Describe your current support system.

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As a result of counseling, what specific results or changes do you wish to see happen?

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If your concerns are resolved and your problems are gone, what would be some of the things you would notice that would tell your life had gotten better?

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Please provide any other information that you feel is important.

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## Checklist of Concerns

Please check the symptoms or concerns that are currently problems for you, or if they are related to your visit. Please circle those that are a priority for your visit. If you think a symptom applies to your family history, please indicate which relatives.

Clinical Symptoms	Situational Concerns
<input type="checkbox"/> Depression	<input type="checkbox"/> Adjustment difficulties
<input type="checkbox"/> Suicidal thoughts or feelings	<input type="checkbox"/> Academic difficulty
<input type="checkbox"/> Suicide attempts _____	<input type="checkbox"/> Occupational stress or employment issues
<input type="checkbox"/> Low energy	<input type="checkbox"/> Transition
<input type="checkbox"/> Low motivation	<input type="checkbox"/> Financial stress
<input type="checkbox"/> Low concentration or focus	<input type="checkbox"/> Problems socializing
<input type="checkbox"/> Memory difficulties	<input type="checkbox"/> Marital or couple problems
<input type="checkbox"/> Loss of interest or pleasure	<input type="checkbox"/> Dating concerns
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Infidelity
<input type="checkbox"/> Excessive crying	<input type="checkbox"/> Conflicts with family members
<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Worries about family members
<input type="checkbox"/> Difficulty making decisions	<input type="checkbox"/> Difficulties with children
<input type="checkbox"/> Low self-esteem or lack of self-confidence	<input type="checkbox"/> Blended family issues
<input type="checkbox"/> Self-harm urges	<input type="checkbox"/> Divorce or break-up
<input type="checkbox"/> Anxiety and stress	<input type="checkbox"/> Anger control issues
<input type="checkbox"/> Anger or irritability	<input type="checkbox"/> Communication difficulties
<input type="checkbox"/> Feeling panic or nervous	<input type="checkbox"/> Conflicts with friends
<input type="checkbox"/> Extremes or unstable mood	<input type="checkbox"/> Death of a family member or friend
<input type="checkbox"/> Unusual elevated mood and high energy	<input type="checkbox"/> Recent traumas
<input type="checkbox"/> Impulsive behaviors or reckless	<input type="checkbox"/> Identity crisis (confused about values, beliefs)
<input type="checkbox"/> Excessive worries	<input type="checkbox"/> Social justice issues
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Existential issues
<input type="checkbox"/> Fear of leaving home	<input type="checkbox"/> Gender related concerns
<input type="checkbox"/> Fear of specific phobia(s) _____	<input type="checkbox"/> Sexual orientation related concerns
<input type="checkbox"/> Paranoia or suspicious	<input type="checkbox"/> Cultural related concerns
<input type="checkbox"/> Lack of social confidence	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Antisocial	<input type="checkbox"/> Health related issues
<input type="checkbox"/> Repetitive behaviors or performing rituals	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Bullying
<input type="checkbox"/> Disordered eating _____	<input type="checkbox"/> Difficulties in sexual relationships
<input type="checkbox"/> Problematic use of alcohol	<input type="checkbox"/> Infertility
<input type="checkbox"/> Substance abuse _____	<input type="checkbox"/> Unwanted pregnancy Abortion
<input type="checkbox"/> Addictions or Dependency _____	<input type="checkbox"/> Postpartum difficulty
<input type="checkbox"/> Negative body image	<input type="checkbox"/> Miscarriage/Stillbirth/Neonatal loss
<input type="checkbox"/> ADHD or ADD	<input type="checkbox"/> Intimate relationship violence
<input type="checkbox"/> Disability _____	<input type="checkbox"/> Sexual abuse/assault
<input type="checkbox"/> Unusual thoughts/perceptions	<input type="checkbox"/> Concerns about your weight
<input type="checkbox"/> Asperger spectrum or Autism	<input type="checkbox"/> Social isolation and loneliness
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Developing independence from family
<input type="checkbox"/> Trauma related symptoms	<input type="checkbox"/> Stealing, cheating or lying
<input type="checkbox"/> Personality issues	<input type="checkbox"/> Legal issues _____
<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	

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**Informed Consent to Receive TeleHealth Treatment for EAP Services**  
**Gisela Lin Counseling and Consultation Services, PLLC**  
**Jun-chih Gisela Lin, Ph.D., ABPP**

Telehealth uses the internet so there will be potential risk for privacy breach. If you find that this mode is not working for you, please inform Dr. Lin so you can discuss other treatment options.

**Client Responsibilities:**

You will need a computer or laptop with a **microphone, speakers**, and a **camera** for video conferencing, or you can click the meeting link with your phone if you have secure internet. You will need a good internet connection and the ability to have space that provides you privacy for your videoconferences.

- My initials here \_\_\_\_\_ indicate my understanding that I cannot participate in video conferencing with Dr. Lin if I am not in the State of Texas.
- My initials here \_\_\_\_\_ indicate my understanding that I must notify Dr. Lin if I am not in the State of Texas and, therefore, am unable to participate in a previously scheduled video conferencing appointment.
- My initials here \_\_\_\_\_ indicate that I am responsible for ensuring my own privacy and confidentiality on my end of a video conferencing appointment with Dr. Lin.

**Appointments:**

Once your appointment is confirmed, if anything changes, Dr. Lin has a policy of 48-hour advance notice to reschedule. If you do not appear for a videoconferencing appointment, you need to contact Dr. Lin to reschedule.

**Ethics, Confidentiality and Record Keeping**

Dr. Lin will use a HIPPA Compliant platform to connect with you. She will also maintain confidentiality and record keeping according to the laws and regulations of Texas as well as follow the professional ethics of the American Psychological Association. You are responsible for maintaining confidentiality on your end of the electronic communication (i.e., being in a private space while video conferencing).

**Emergency/Crisis Situations:**

Dr. Lin does not provide 24-hour crisis counseling. you understand that in case of crisis, if you cannot reach Dr. Lin at 979-314-9698, you can call your local MHMR number, or call 988 Suicide and Crisis Lifeline, or call the National Suicide Prevention Lifeline 1-800-273-TALK (8255). If you have a life-threatening emergency, you should call 911, or go to the nearest hospital emergency room.

**If Dr. Lin Becomes Concerned for Your Safety**

If Dr. Lin becomes concerned for your safety, she will contact you by phone to check on your well-being. In addition, she may contact others as necessary. For that reason, Dr. Lin asks your permission to contact others as necessary to ensure your safety. Consistent with national standards, Dr. Lin requires three levels of contacts to be identified in order to participate in online services:

1. A personal contact such as a parent, spouse, relative or close friend

**Personal Contact:** \_\_\_\_\_  
Name Relationship Phone

2. A professional contact such as a personal physician

**Professional contact:** \_\_\_\_\_  
Name Relationship Phone

3. The office or agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

**Crisis Response:** \_\_\_\_\_  
Agency Phone

**Agreement to Contact Me or Others**

If I show signs of distress that indicate that I may be in danger, I grant Dr. Lin permission to contact me by phone. \_\_\_\_\_  
Initial

If I show signs of distress that indicate I may be in danger, and I fail to respond to phone or phone messages, I grant Dr. Lin permission to contact my personal and/or professional contacts to verify my well-being.  
\_\_\_\_\_  
Initial

If I show indicators that I may be at serious risk for self-harm or harm to others, I understand that Dr. Lin will notify the **Crisis Response** contact above so that someone can check on my safety. This may take the form of a wellness check conducted through the local police.  
\_\_\_\_\_  
Initial

If there is a disruption in video connectivity during a video session, the counselor may call me at \_\_\_\_\_.  
\_\_\_\_\_. If I am not able to answer, I understand that the counselor will email me at \_\_\_\_\_  
\_\_\_\_\_ to verify our next video conferencing appointment date and time.  
\_\_\_\_\_  
Initial

My initials indicate understanding of the following:

\_\_\_\_\_ I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization who obtained my initial consent. I understand the revocation will not apply to my participation up to my revocation.

\_\_\_\_\_ I have been informed about the purpose, expectations, possible benefits, risks, and crisis procedures. I agree to participate in Telehealth, and I consent to participate in on-line treatment with Dr. Lin.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name