Woodlands Family Institute, P.C.
1610 Woodstead Ct., Suite 420
The Woodlands, TX 77380

(281) 363-4220 Fax: (281) 364-9404
www.wfipc.com

PERSONAL DATA RECORD

Client Name: ____________________ Date of Birth ____________

Address: ____________________

City/State/Zip: ____________________

Home Phone: ____________ Work Phone: ____________

Cell Phone: ____________ Other Phone: ____________

SSN: ____________ TXDL: ____________

Employer/School: ____________________

Referred to Our Office by: ____________________

May we send a Thank You card to the person who referred you? (Circle One) Yes No
May we mention your name in that Thank You card? (Circle One) Yes No

EMERGENCY CONTACT

Name: ____________________ Relationship: ____________

Address/Phone: ____________________

CONSENT FOR TREATMENT

Client Name: ____ Birthdate: _______________________

I give full consent for **myself** or my **child/adolescent** to receive outpatient mental health services until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

____ ______________________________

Signature of *Client, Client's Parent* or *Legal Guardian* Date

AUTOMATIC PAYMENT

If you would like us to automatically charge your credit/debit card for your fee, please provide the information below:

MC/Visa No. Exp. Date

Name as Listed on Card: ____________________ ____________

Signature of Authorized User: ____________________

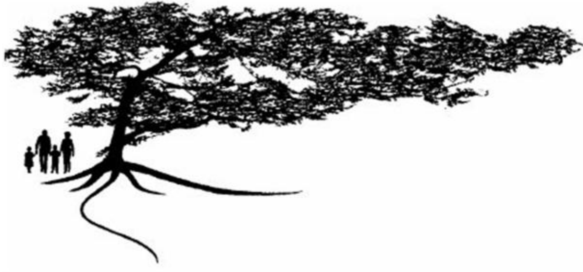
FINANCIAL RESPONSIBILITY

Name of person(s) financially responsible for this account: ____

Address(es): ____

Signature(s): ____ _____

Relationship(s) to client: ____



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FEE SCHEDULE:

STANDARD RATE: $160.00 per standard 45 minute session or prorated accordingly. Charges for other professional services are prorated on the basis of $150.00 per hour ($2.50 per minute). These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. In limited and special cases, 30 minute sessions are available at the rate of $100.00 per session. These sessions must be approved by the therapist and meet specific standards.

Service charge for returned checks is $15.00. Cash, personal checks, Visa and MasterCard are accepted forms of payment.

FORENSIC RATES: $500.00 per hour (or portion of hour) for expert witness court testimony or deposition, plus $150.00 per hour for local travel, waiting and preparation for testimony. For out-of-area court appearance, all transportation and lodging expenses must be paid in advance. Records review, consultations with clients, litigants, attorneys (in person or via telephone), reports or any other service provided will be charged at the rate of $150.00 per hour or prorated accordingly. Please be aware that I do not provide consultation, evaluation or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who specialize in these issues.

PAYMENT POLICY: Payment is due in full at the time of service. If you elect to seek reimbursement from your carrier, we will provide you with an insurance-ready receipt to assist you in completing your claim. We will consult your third-party payer only at your direction, with such consultations billed to your account.

PLEASE BE AWARE THAT THIRD-PARTY PAYERS REQUIRE THE DISCLOSURE OF YOUR DIAGNOSIS AND SUPPORTING CLINICAL DATA! OUR OFFICE IS COMPLETELY COMPLIANT WITH HIPAA PRIVACY REGULATIONS BUT CANNOT GUARANTEE THAT YOUR PAYER FOLLOWS THE SAME PROCEDURES!

Some carriers reimburse clients for services, and some do not. We advise you to contact your company representative to determine the specific provisions of your policy’s reimbursement allowances. Please understand that you are ultimately responsible for keeping your account current and failure to do so may result in collection agency intervention, or in some cases, litigation through small claims court.

ACCEPTED POLICIES BETWEEN CLIENT AND THERAPIST

1. Therapist will make every effort to see client on time as scheduled by client and therapist. Client must make every effort to be on time for appointment.

2. **CLIENT MUST PROVIDE FORTY-EIGHT HOURS NOTICE FOR CANCELLATION OF APPOINTMENT TO AVOID BEING CHARGED FOR THE APPOINTMENT.**

3. Cell phones should be turned off during therapy so that client and therapist can remain focused on the very important and delicate work of therapy.

4. The relationship between the therapist and client is professional. The therapist is bound by a code of ethics which prohibits dual relationships. It is not ethical for the therapist to honor invitations by the client which involve social relationships and/or other interactions outside the therapeutic relationship.

5. Children of all ages are special and wonderful. However, children require special attention which may interrupt the therapeutic process. It is not possible for our office to provide child care; therefore, we recommend that the client make off-campus child care arrangements prior to the scheduled appointment.

6. The therapist's schedule is intense and it is difficult to make changes. The client is asked to take special care when scheduling appointments to avoid the need for changes.

7. Our therapy is considered outpatient and assumes that the client is able to manage day-to-day stress between sessions. Telephone calls between sessions should rarely be necessary. Nevertheless, in the event of an **after hours emergency,** please contact our answering service @ 713-866-4494, **clearly state that the call is an emergency,** and request that they page me. I will then respond as promptly as possible. If I am unable to respond quickly enough, please call 911 or proceed to your nearest hospital emergency room. Routine, **non-emergency** calls will be returned during normal business hours.

8. Termination of therapy should be conducted during a regularly scheduled session to provide proper closure to the therapeutic relationship.

9. Preservation of your confidentiality will be absolute with the following exceptions: a) you direct me to disclose information to another party, b) I determine that you are a danger to yourself or others, c) I am ordered by the court to disclose information, d) there is a reasonable suspicion of abuse to a child or elderly person.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. I also understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

Signature ____ Date _______________

IMPORTANT INFORMATION RELATING TO THE UTILIZATION OF INSURANCE

Managed Health Care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Under these plans, it may be necessary to seek approval for more sessions periodically. You should also be aware that contracts with health insurance companies generally require that we provide them with information relevant to the services you are being provided. We are usually required to provide a clinical diagnosis. Sometimes, additional clinical information such as treatment plans or summaries is also required. In such situations, we make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over its use. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

*****PRIVATE-PAY CLIENTS PLEASE NOTE!!!! It is advisable for you to contact your carrier to verify the network status of your therapist before your first appointment! If at a later date it is determined that your therapist is indeed a participating provider on your policy and you have not provided our office with sufficient carrier identification information; you will not be refunded the difference between our normal fees and any reduced contracted fees that may apply to your policy!!!*****

Confidentiality: The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide written, advance general consent. Your signature on our Acknowledgment form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently, please let us know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with some business services, such as the answering service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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 IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *general consent.* To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my 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.
- "Use" applies only to activities within WFI such as utilizing information that identifies you.
- "Disclosure" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and 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. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.

- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or 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.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

~~This notice will go into effect on 3/28/2005. We reserve the right t~~o change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

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Please indicate below how we may contact you and whether we can leave a message:

☐ Home Phone May we leave a message (Circle One)? Yes No

☐ Work Phone May we leave a message (Circle One)? Yes No

☐ Cell Phone May we leave a message (Circle One)? Yes No

☐ Unencrypted (normal) email (address):____

If you would like us to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other (Specify) ____

You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.

ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and the **Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

____

Client or Authorized Representative Signature Date

☐ Refused to Sign

☐ Unable to Sign (Specify Reason) ____

____

Signature of Person Documenting Refusal or Inability to Sign Date