Stonebridge Family Counseling

Independent Private Practices of:
Teresa Bryan-Pettit, LCSW Vicky Lindsey, LCSW Darla Burton, M.Ed., LPC Ann Dillon, M.Ed., LPC

Welcome, and thank you for choosing Stonebridge Family Counseling. The following information is needed in order to serve you properly. All information is strictly confidential.

Date _____

Client's Name _____ Sex: ____ Male ____ Female

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ May we call you at home? Yes _____ No _____
Cell Phone ( ) _____
Work Phone ( ) _____ May we call you at work? Yes _____ No _____
E-mail address: _____
Age _____ Date of Birth ___/___/___ Social Security # ____-____-____ Driver's License # _____

Marital Status: Single ____ Divorced ____ Widowed ____ Married ____ Spouse's Name _____
Years Together _____

Names of other family members in household	Sex	Date of Birth	How related	Social Security #
_____	____	_____	_____	____-____-____
_____	____	_____	_____	____-____-____
_____	____	_____	_____	____-____-____
_____	____	_____	_____	____-____-____

Client/Guardian Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone ( ) _____ How related? _____
I authorize my therapist to communicate verbally with _____ regarding appointments, general medical information or referral information.

Name of Insured: _____ Insured's: SS# ____-____-____ DOB _____
Insurance Company _____
Insured's Employer _____ Address _____
City _____ State _____ Zip _____ Phone ( ) _____
Name of Contact _____

Group Number _____ ID Number _____

Secondary Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Name of Contact _____

Group Number _____ ID Number _____

Recipient of Medicaid? _____ Number _____ Medicare? _____ Number _____

What concern(s) bring you to counseling at this time? _____

_____

What changes would you like to see as the result of counseling? _____

_____

Please list any previous counseling experiences:

Date _____ Therapist's Name _____ Helpful? Yes ____ No ____

Date _____ Therapist's Name _____ Helpful? Yes ____ No ____

Have you been hospitalized in the past? Please include medical, psychiatric or chemical dependency.

Date _____ Hospital _____ Reason _____

Date _____ Hospital _____ Reason _____

Are you currently under a physician's care? Yes __ No __ Name _____ Phone ( ) _____
I _____ authorize/do not authorize my therapist to communicate with my physician.

List any current medical conditions: _____

_____

List all current medications and dosages: _____

_____

Please include any other information you feel in important for us to know at this time: _____

_____

How did you learn about Stonebridge Family Counseling? _____

I authorize my therapist to release any and all information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Client, Parent or Guardian Signature _____ Date _____

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This form provides you with information that is additional to that detailed in the Notice of Privacy Practices. Please read the following information carefully and discuss any questions you may have with your therapist.

Therapist

The undersigned therapist is a licensed professional counselor or clinical social worker engaged in an independent private practice providing mental health services to clients directly and as an independent contractor/provider for various managed care entities. The undersigned therapist provides mental health services through Stonebridge Family Counseling; however, there is no partnership or corporation associated with the name Stonebridge Family Counseling.

Mental Health Services/The process of Therapy

Services offered include, but are not limited to, individual, couples and group counseling. While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family) or psychoeducational.

Appointments

Appointments are made by calling (903)893-6010 Monday through Friday between the hours of 9:00am and 5:00pm. Please leave a message and your call will be returned as soon as possible. Messages are checked several times throughout the day. You must call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Account Balances and Credits

The credit card on file is to be used for balances of charges not paid within 30 days and cancellation fee if an appointment is not cancelled within the 24 hours. Balances not paid within 30 days will be sent to a collection agency.

Cancellations

Cancellations must be received at least 24 hours before your schedules appointment; otherwise you will be charged the customary fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Office Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Therapy sessions are 45 minutes in length. In order to preserve the professional atmosphere of our office, we must limit the noise and number of people in our waiting area. **Unless a child is the client, children should not be bought to the office.** Children who are clients must be accompanied by an adult at all times in the waiting area and should be on their best behavior. Children should not be allowed to have food or drinks in the office.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to reserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Fees

The maximum fee for the initial visit is $125.00. The charge for a 45 minute session is $95.00, and payment is due at the time of service. Each therapist has a sliding scale for private pay that is based on income. This will need to be discussed with your therapist prior to your first session. Other services such as assessment/psychological testing/report writing, extended sessions, court appearances, phones calls over five minutes, etc. constitute additional charges. Missed sessions without 24-hour notice will be charged $60.00. The undersigned therapist contracts with several managed care, EAP and insurance companies. You must present valid and current proof of any insurance coverage in effect. If you are going through your EAP, you are responsible for contacting them to obtain authorization prior to the first session. It is the patient's responsibility to provide provider with the correct insurance information in order to file claims with the insurance company. Claims not paid due to incorrect information will then become the patient's responsibility. Different co-payments are required by various group coverage plans. Your co-payment is based on the mental health policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company. You are responsible for any co-pay or deductible that has to be met on your insurance policy. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges. Please talk openly with your therapist if you have a financial hardship. Please take care of any financial matters, such as co-payments and deductibles, at the beginning of each session. If you are paying cash, you must bring exact change, as we do not keep cash in the office. All checks should be made payable to your individual therapist. Returned checks will be charged a $20.00 fee. My Deductible $_____ Insurance Coverage % _____ or $_____ per session Co-pay % _____ or $_____ per session.

You must be aware that submitting a mental health invoice for payment or reimbursement to your insurance carrier carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon may also be reported to the Congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database has always been in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical date has been reported to have been sold, stolen or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Records

Patients have a legal right under HIPAA to a copy of their medical records. However, if patients request copies of their medical records as permitted by the Privacy Rule, they may be required to pay for the copies. If we are asked to make copies of records for you or someone on your behalf (including attorneys), it will be a fee of $25 for first 20 pages then 50 cents per page for every copy thereafter. In addition, you will be charged the actual cost for mailing or shipping if we have to mail the copies.

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure and exceptions to confidentiality were described to you in the Notice of Privacy Practices that you received with this form. Some of the circumstances where disclosure is required by

the law are: when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and when a client presents a danger to self or to others or is gravely disabled (for more details see Notice of Privacy Practices). In couple or family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will use her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless she is authorized to do so by **all** adult family members who are or were part of the treatment. The Sherman-Denison area is a small community and many clients know each other and/or the therapists from the community; consequently, you may bump into someone you know in the waiting room or into your therapist out in the community. If you are seen in public, your confidentiality will be protected by acknowledging you only if you approach first.

Confidentiality of E-mail, Cell Phone, Text and Fax Communication

It is very important to be aware that e-mail and cell phone communication can be accessed relatively easily by unauthorized people, hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist in writing at the beginning of treatment in you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mails or faxes for emergencies.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact my spouse, parents or emergency contact on my information form, in addition to medical and law enforcement personnel.

Communication

I consent for the undersigned therapist to communicate with me by mail and by phone at the addresses and phone number listed on my information form, and I will IMMEDIATELY advise the therapist in the event of any change.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involved making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf will call on the undersigned therapist to testify in court or at any other proceeding, not will a disclosure of the psychotherapy records be requested. However, if I am subpoenaed I normally provide the requested information whether or not he information in favorable to the undersigned. Should you subpoena me as a factual witness or involve me in court-related processes a retainer fee of $1500 is required with a charge of $250 per hour I am involved in case preparation, reports, phone calls, travel and witness time.

I have read & understand the litigation limitations, that legal proceedings are strongly discouraged due to the nature of confidentiality. If in spite of this discouragement, the therapist is compelled as stated in informed consent document, there will be a retainer fee of $1500 and an additional $250 per hour for every hour therapist is involved in case preparation, reports, phone calls, travel and witness time. Initial: _____

After-Hours Emergencies

You may reach your therapist outside of office hours by calling the alternate number provided on your therapist's business card and leaving a message if there in no answer. **If you have a life-threatening emergency, you should dial 9-1-1 or the 24-hour Crisis Hotline at (903)893-5615 or go to the nearest hospital, such as Texoma Medical Center, Wilson N. Jones Hospital or TMC Behavioral Health Center, 2601 Cornerstone Dr., Sherman (903)416-3000.**

Referrals and Termination or Therapy

After the first couple of meetings, your therapist will assess if she can be of benefit to you. Your therapist does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals you can contact. If at any point during therapy your therapist assesses that she is not effective in helping you reach your therapeutic goals, she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time. If

you choose to do so, your therapist will offer to provide you with names of other qualified professionals whose service you might prefer. You will be responsible for contacting and evaluating any referrals and/or alternatives.

Therapist's Incapacity or Death

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health profession selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Consent to Treatment

I, voluntarily, agree to receive a mental health assessment, care, treatment or services, and authorize the undersigned therapist to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services, and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time. By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. In addition, my signature confirms consent to treatment for myself, or if clients is a minor child, his or her name is printed below with my signature confirming consent to treatment and certifying that I am the child's parent, guardian or managing conservator and have the legal right to consent to such services on behalf of the child. I understand that I am responsible for paying any charges denied by my insurance company.

My signature below verifies that accuracy of this statement and acknowledges my commitment to the above guidelines.

_____	_____	_____
Client's signature or Child/Minor's name	Parent/Guardian/Managing Conservator's signature	Therapist's signature
_____	_____	_____
Date	Date	Date

I acknowledge access to the HIPPA Notice of Privacy Practices, Posted in the office. Also available for taking home.

Name: _____ Date: _____ Signature _____

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COURT TESTIMONY AGREEMENT & INFORMATION

It is in your best interest to know that I am not considered a Forensic psychologist and conducting witness/testimonial services is not in my area of expertise. If you have a suspicion that your case will be going to court or you need a therapist's forensic testimony please let me know and I will provide you with an appropriate referral source that can meet your needs.

Should you involve me in legal or court related processes and/or you subpoena me as a factual case witness you agree to pay a retainer fee of $1500.00 which includes a $500.00 non-refundable deposit. My fees for court related services are $250.00 for every hour of the therapist's time involved, including but not limited to phone consultation with client and/or client's attorney about court hearing, drive time, wait time, court testimony and/or deposition, paperwork preparation and any other legal matters. If you or the opposing party choose to have me subpoenaed with or without my approval from either party the above charges will apply.

Please note that the role of a therapist, who is compelled by subpoena to appear in court for a hearing on parenting issues, is limited. The American Association for Marriage and Family Therapy (AAMFT) Code of Ethics Principle 3.14 provides: "To avoid a conflict of interest, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence or visitation of the minor. The marriage and family therapist who treats the minor may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective."

(Initial one of the following)

_____ I AM seeking counseling for court testimony or court involvement on behalf of therapist.

_____ I AM NOT seeking counseling for court testimony or court involvement on behalf of therapist.

_____ I AM seeking counseling to obtain disability through my company or Medicare.

By signing this form, you are acknowledging that you have let the therapist (before a counseling relationship is established) know if you and/or your child is attending counseling for court or court-related purposes/motivations or under the advisement of an attorney. This includes divulging if you have hired an attorney and/or are involved in any child custody or visitation issues.

Your signature below indicates that you have read and understand this document and any questions you had about this document were answered to your satisfaction. You agree to waive your therapist's involvement in any legal matters they deem not appropriate for their participation.

Signature_____Date_____

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Fee Policy

Balances Due on Account

We ask that patients pay for their office visit at the time service is rendered. For balances on the account, the client is required to pay the full amount before the client can resume counseling unless an alternate payment plan has been agreed upon.

Cancellation Policy and Account Balance

It is our policy to charge $60.00 for appointment that are not cancelled at least 24 hours in advance. Your communication with us about appointment cancellations allows us to offer that time slot to someone else who needs to be seen.

Credit Card Authorization

I authorize my therapist at Stonebridge Family Counseling to keep my signature on file to charge my credit card account for balances of charges not paid within 30 days and for cancellation fee if an appointment is not cancelled within 24 hours. Cancellation fee will be charged to my credit card on the day of the missed appointment.

I authorize balances for charges not paid within 90 days to be sent to a collection agency.

Visa MasterCard American Express Discover

Cardholder Name (as it appears on the card) _____

Card Number _____ Security Code _____

Expiration Date _____ Billing Address _____

City _____ State _____ Zip _____

Signature _____ Date _____