



AGREEMENT FOR SERVICE/INFORMED CONSENT

Fee Arrangements

The usual and customary fee for service is \$120 for a 45-50 minute session. I reserve the right to periodically adjust this fee. You will be notified for any fee adjustments in advance. In addition, this fee may be adjusted by contract with insurance companies or other third party payors or by agreement with me. Please be aware that insurance companies have restrictions on what they will cover and not all issues that may bring someone to therapy are covered by insurance. If you are paying out of pocket/private pay, you are responsible for paying the full fee at the time of service. If you are using out of network benefits, you are also responsible for paying the full fee at the time of service. I will then file your claim for you for reimbursement from your insurance company. If I am in network for your particular mental health insurance coverage, then you are responsible for paying your estimated portion (deductible, copay, coinsurance) at the time of service and I will bill your insurance for the remainder. You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, and any other third party payor. You are responsible for contacting your insurance company to verify and understand my status as an "in network" or "out of network" provider for your plan, the limits of your coverage for mental health/behavioral health services, as well as your co-payments and deductibles, and obtaining preauthorization, if required. If you must cancel or reschedule an appointment, please leave a voicemail indicating so at least 24 hours in advance of your scheduled appointment or a \$25 fee will be charged. A credit card is kept securely on file for cancellation fees and other fees that you are responsible for paying.

Confidentiality

Therapy sessions are confidential. There are some legal and ethical exceptions to this confidentiality including; danger to self and others, and suspicion of child, elder, and dependent adult abuse. No secrets policy for couples and families: Information shared with me by one participant will be open for discussion with the other participants, when clinically appropriate.

Risks and Benefits of Therapy

Psychotherapy is a process in which we will discuss a myriad of issues, events, and experiences for the purpose of creating positive change so that you can experience your life more fully. Psychotherapy is a joint effort. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thought and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on your part, as well as family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some emotional discomfort. There may be times in which I will challenge the perceptions and assumptions of you and other family members, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. I do not make decisions about your life and your relationships for you. I will help explore and discuss issues and options, but you will make the decisions.

Dual Relationships

I will avoid a therapeutic relationship with a personal friend, educational or business associate and will avoid the development a personal, educational or business relationship with a therapy client.

Termination of Therapy

If at any point during therapy, I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would

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give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time.

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute, in which you and another individual, or entity, are parties. I have a policy of not communicating with your attorney and will not generally write or sign letters, reports, declarations, or affidavits to be used in your legal matter. I will generally not provide records or testimony unless compelled to do so. I will not make any recommendation as to custody or visitation. I will make efforts to be uninvolved in any custody dispute. It is agreed that should there be legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Complaints

Complaints may be made to the Texas State board of Examiners of Marriage and Family Therapists at Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540.

Acknowledgement

By signing below, you consent to treatment and acknowledge that you have reviewed and fully understand the terms and conditions of this agreement. You agree to abide by the terms and conditions of this Agreement and consent to participation in psychotherapy with me. Moreover, you agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. By signing below, you also authorize communication with the referring party for the purpose of assessment and treatment planning.

Adult Client Name	Date of Birth	Signature	Date
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Adult Client Name	Date of Birth	Signature	Date
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Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date
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Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date
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I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Name of Financially Responsible Person (printed)	Signature	Date Signed
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CREDIT CARD AUTHORIZATION

I authorize Susan Martinez to charge my credit card \$25 for no showing to a scheduled appointment or canceling with less than 24 hours notice and also for any balance due that is owed due to my insurance company not covering services or due to a nonpayment on my behalf.

Type of card: _____

Card Number: _____

Expiration date: _____

Security Code: _____

Cardholder Name: _____

Cardholder Billing address: _____

Cardholder Signature and date: _____

INSURANCE INFORMATION

Please also attach a copy of the front and back of your insurance card.

PATIENT NAME:

ADDRESS:

PHONE: SS#

DOB:

SEX: EMPLOYER:

PATIENT OCCUPATION: MARITAL STATUS:

Is patient's condition related to: employment? Y/N Auto accident? Y/N Or other accident? Y/N

PRIMARY INSURED NAME:

ADDRESS:

PHONE: SS#

DOB

SEX EMPLOYER:

OCCUPATION: MARITAL STATUS:

INSURANCE PLAN NAME OR PROGRAM NAME:

INSURANCE PHONE NUMBER:

ADDRESS TO SUBMIT CLAIMS TO:

INSURED ID #:

INSURED POLICY GROUP OR FECA NUMBER:

IS THERE ANOTHER HEALTH BENEFIT PLAN? If yes, provide additional information.

COPAY: DEDUCTIBLE:

PRECERTIFICATION REQUIRED/RECEIVED? Y/N AUTHORIZATION NUMBER?

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Susan Martinez, MA, LMFT.

Date Signature

I authorize payment of medical benefits to Susan Martinez, MA, LMFT.I hereby authorize Susan Martinez, MA, LMFT to apply benefits on my behalf for covered services rendered by Susan Martinez, MA, LMFT. I request that payment from my insurance company be made directly to Susan Martinez, MA, LMFT. I certify that the information I have reported with regard to my insurance coverage is correct.

Date Signature

HIPAA NOTICE OF PRIVACY PRACTICES (First Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I will only release healthcare information about you in accordance with federal and state laws and ethics of the marriage and family therapy profession. According to federal law, I am designated as the "Privacy Officer" for my practice. I may, use and disclose health information about you in the following instances: Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary for quality care. State and Federal laws allow me to use and disclose your health information for these purposes.

1. Treatment: I may use information about you to provide, manage and coordinate mental health treatment. For example, to coordinate care with another mental health professional that treats you, I may disclose relevant information about your diagnoses or treatment.
2. Payment: I may disclose health information about you to verify insurance and coverage and process claims and collect fees. For example, I may need to give diagnostic codes, symptom information, or progress reports to the insurance company.
3. Healthcare Operations: I may disclose health information for the review of treatment procedures, review of business activities, certification, staff training, compliance and licensing activities.
4. Vacation and Emergency Coverage: In the event of vacation or emergency, I may disclose sufficient information about you to another professional to ensure that you are notified and assisted.
5. Disability, Health, or Life Insurance: I may release information about your condition and your treatment if you seek financial compensation for a disability or when required by health insurance or life insurance applications.
6. Military, Veterans, National Security, or Intelligence: If you are or were a member of the Armed Forces or a national security or intelligence community, I may be required by military command or other government authorities to release health information about you.
7. Threats to Safety: It is my policy, and I am required by law to disclose information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of anyone else. I am required by law to do so if I am concerned about suicide or homicide.
8. Child Abuse or Neglect: It is my policy, and I am required by law, to disclose information about you when I suspect or witness the abuse of a minor child or adolescent or a dependent adult to the appropriate social service agency (e.g., Child Protective Services).
9. Other Circumstances: The law may require a disclosure from me including public health risks, legal subpoenas, court orders, warrants, summonses or similar processes.
10. Unidentifiable Personal Information: In order to maintain the highest quality of care, I may obtain consultation on general issues of your situation without using any identifiable information such as your name, age, occupation, etc. In these cases, I will disclose only such information as is necessary to obtain the consultation and will do so only for the purpose of improving my ability to provide you with good treatment.

The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. **If Texas law protects your confidentiality or privacy more than the federal "Privacy Rule" does, or if Texas law gives you greater rights than the federal rule does with respect to access to your records, I will abide by Texas law.** In general, uses or disclosures by me of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when I request your personal health information from another health care provider, health plan or health care clearinghouse, I will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, in the section dealing with uses or disclosures for treatment purposes, the "minimum necessary" standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

I reserve the right to change this notice. I reserve the right to make a revised or changed notice effective for medical information I already have about you, as well as any information I receive in the future. I will give you a copy of the current notice, with the effective date, at the time I implement any changes.

Your Rights Regarding Protected Health Information

1. You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction.
2. You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations.
3. You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my “psychotherapy notes.” The term “psychotherapy notes” means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
4. You have the right to amend protected health information in my records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, I am permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.
5. You have the right to receive an accounting from me of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, I am permitted to deny the request for specified reasons. For instance, I do not have to account for disclosures made in order to carry out my own treatment, payment or health care operations. I also do not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you might sign.
6. You have the right to obtain a paper copy of this notice from me upon request.
7. You have the right to complain. If you are concerned about your privacy, please discuss your concerns with me. If you believe your privacy rights have been violated, you may file a written complaint to me by mailing it to PO Box 2401 Keller, TX 76244. If you are not satisfied, you may complain also to the Secretary of the U.S. Dept of Health and Human Services at Region VI, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202.. You will not be penalized or discriminated against for filing a complaint.
8. You have the right to release your medical records. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information “in a specific and meaningful fashion.” You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the notice of privacy practices of Susan Martinez, MA, LMFT. My privacy practice notice provides information about how I may use and disclose health information that I maintain about you.

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Adult Client Name	Date of Birth	Signature	Date
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Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date
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Susan Martinez, MA, LMFT	Date
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