Mid Cities Counseling Center, PLLC
255 Elk Dr. Ste. B Burleson, TX 76028 - 5005 Colleyville Blvd. Ste. 216 Colleyville, TX 76034
Phone: (817) 888-8131

AGREEMENT FOR SERVICE/INFORMED CONSENT

Fee Arrangements

Payment is due at the beginning of each session. The usual and customary fee for service is $125.00 for a 45 minute session, $150.00 for a 60 minute session, $175.00 for an initial assessment and $150.00 for a 50 minute couples session. We reserve the right to periodically adjust this fee, with advance notice. In addition, this fee may be adjusted by contract with insurance companies or other third party payors or by agreement with us. 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. You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, and any other third party payor.

Cancellations

If you must cancel or reschedule an appointment, please leave a voicemail at your providers direct extension or send a secure email via your patient portal indicating so **at least 24 hours in advance** of your scheduled appointment or a $55 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 your therapist 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 you and your provider will discuss a myriad of issues 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 thoughts and 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 your provider 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. Therapists do not make decisions about your life and your relationships for you, but will help explore and discuss issues and options, ultimately, you will make the decisions.

Dual Relationships

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

Termination of Therapy

If at any point during therapy, your provider makes the assessment that they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, you would be given a number of referrals that may be of help to you. You have the right to terminate therapy at any time.

Client Litigation

Your provider will not voluntarily participate in any litigation, or custody dispute, in which you and another individual, or entity, are parties. It is agreed that should there be legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If compelled, the billing rate is $125.00 per hour for all services including but not limited to: attorney consultation, document review, court testimony, and wait time in court, report writing, case correspondence, travel time, and all other

services relating to forensic activities. Should your providers testimony or a report be required, payment of the equivalent of a one day retainer $1,000.00 will be required in advance and must be attached to the subpoena. Cancellation of any court hearing or meeting will be charged a $500.00 cancellation fee for each cancellation or rescheduling with less than 24 hour notice.

Complaints

Complaints may be made to the Texas State board of Social Work Examiners at P.O. Box 149347 mail code 1982 Austin, Texas 78714-9347 or call 1-800-942-5540. An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information.

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 your provider. Moreover, you agree to hold your provider and Mid Cities Counseling Center, PLLC 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.

Print Client Name Date of Birth Signature Date

Print Client Name Date of Birth Signature Date

*Minor Client Name Date of Birth Signature of parent/guardian Relationship to minor Date

*If client is a minor, is there a divorce decree or custody agreement?___Yes ___No (check one AND initial *I attest that this information is true and correct *_____). If yes, you MUST bring a copy of the decree/agreement PRIOR to the first appointment and/or BOTH legal parents must sign this consent to treatment form.

I understand that I am financially responsible to Mid Cities Counseling Center, PLLC 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 Mid Cities Counseling Center, PLLC to charge my credit card $55 if I "no show" to a scheduled appointment or cancel with less than 24 hours' notice. I also authorize charges for any balance due that is owed due to my insurance company not covering services or due to a nonpayment on my behalf.

Card Number: _____

Expiration date: month _____ day _____ year _____

Security Code: _____

Cardholder Name: _____

Cardholder billing zip code: _____

Cardholder Signature: _____date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

The effective date of this Notice is September 1, 2013.

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. Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or providing one to you at your next appointment. **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. **For Payment**. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities, or collections. **For Health Care Operations**. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. **Required by Law**. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule. **Without Authorization**. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. **Child Abuse or Neglect, Suicidal**. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, danger to self (suicide). **Judicial and Administrative Proceedings**. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process. **Deceased Patients**. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. **Medical Emergencies**. We may use or disclose your PHI in a medical emergency situation. **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third- party payors based on your prior consent) and peer review organizations performing utilization and quality control. **Law Enforcement**. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in

connection with a crime on the premises. **Specialized Government Functions**. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. **Public Health**. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. **Research.** PHI may only be disclosed after a special approval process or with your authorization. **With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices. **YOUR RIGHTS REGARDING YOUR PHI** You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our **Privacy Officer, Shemila Chancellor, LCSW at phone: 817-888-8131. Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer with any questions. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service for out of pocket. In that case, we are required to honor your request for a restriction. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request. **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself. **Right to a Copy of this Notice.** You have the right to a copy of this notice. **COMPLAINTS** If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Privacy Officer, Shemila Chancellor, LCSW at Address: 255 Elk Drive Suite B Burleson, TX 76028 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the notice of privacy practices of Mid Cities Counseling Center, PLLC. My privacy practice notice provides information about how I may use and disclose health information that I maintain about you.

Adult Client Name	Date of Birth	Signature	Date

Adult Client Name	Date of Birth	Signature	Date

Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date

_____ _____

Therapist Signature Date

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Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message) the day before your scheduled appointments. This service is a courtesy.

Depending on your therapists' preference, you may also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may use the option to **set a repeating appointment** at your preferred day/time several months out to ensure that your preferred appt day/time is available to you. You can still cancel or reschedule occasionally and when you complete therapy any future sessions in the calendar will be cancelled. If you schedule week by week, you run the risk of someone else booking your preferred day/times. Please check with your therapist to see what option is available to you.

Patient Name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |_p_|_a_|_s_|_s_|_w_|_o_|_r|_d_|__1|__| (if re-set needed) Please set your own PW when registering.
(letters or numbers only)

Your email address: _____

Your cell phone number: (_____) _____ - _____

We typically send text reminders (initial below). You must initial email for any email communication. Would you like to receive appointment reminders? (Initial below)

_____ Via a text message on my cell phone listed above (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

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INSURANCE INFORMATION

Option A: Health Insurance Waiver: I waive insurance benefits for therapy sessions with my licensed therapist at Mid Cities Counseling Center. I will cash pay directly the usual and customary fee of $125.00 per 45 or $150.00 per 60 minute therapy session. Neither of us will be filing claims with the insurance company. Reduced fee is extended on a case by case basis. Reduced fee of $_____ (if applicable).

Date Signature

Option B: I choose to use my insurance and file insurance claims for covered services. I understand my licensed therapist at Mid Cities Counseling Center will file the claims for primary insurance for me as a courtesy. **Please also attach a photocopy of the front and back of your insurance card and front of your (or parent/guardian) driver's license.**

BEHAVIORAL HEALTH INS PLAN (check one): __ Aetna PPO; __Blue Cross Blue Shield PPO; __Cigna PPO; __United Health Care PPO; __Magellan; __EAP Aetna Resources for Living; __EAP AWP; __EAP Cigna; __EAP UBH; ___Out of Network/Other (please list)_____
INSURANCE PHONE NUMBER:_____
ADDRESS TO SUBMIT CLAIMS TO: _____
INSURED ID #: _____ GROUP #:_____
COPAY/CO-INSURANCE: $_____ DEDUCTIBLE INFO: $_____MET to date $_____
Is individual outpatient psychotherapy covered? (CPT code 90834 and/or 90837)___Yes ___No
Is TELE Health/Virtual Visits Covered? (CPT code 90834 or 90837 w/95 modifier)___Yes___No
Is Family therapy covered? (CPT code 90847) ___Yes___No___N/A
REQUIRED FOR EAP precertification required/received ___Y___N
Authorization#_____
#of session's authorized_____expiration date_____
PATIENT NAME: (first)_____ (last)_____
ADDRESS:_____city
PHONE:_____SS# _____-___-_____DOB: mo_____day_____year_____
Gender: __M__F__Other Marital Status: __Single __Married __Other
PRIMARY INSURED/Subscriber Info (IF DIFFERENT THAN PATIENT):
NAME: (first)_____ (last)_____
ADDRESS:_____City_____State_____Zip_____
PHONE:_____SS# _____-___-_____DOB: mo_____day_____year_____
Gender: __M__F___Other Marital Status: __Single __Married __Other
Relationship of Patient to Primary Insured: (check one) ___self ___child/dep ___ spouse___other

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 Mid Cities Counseling Center. I authorize payment of medical benefits to Mid Cities Counseling Center. I hereby authorize Mid Cities Counseling Center to apply benefits on my behalf for covered services rendered by my licensed therapist. I request that payment from my insurance company be made directly to Mid Cities Counseling Center. I certify that the information I have reported with regard to my insurance coverage is correct. *We DO NOT file secondary claims.

Signature Date

TELEMEDICINE INFORMED CONSENT

This Informed Consent form is intended to inform you about Mid Cities Counseling Center, PLLC's policies and procedures regarding Telemedicine Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, have acknowledging that you understand and agree that Mid Cities Counseling Center, PLLC will provide therapy to you according to this Telemedicine Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telemedicine Services, and agreed upon before any Telemedicine services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telemedicine and Telementalhealth services. Please print a copy of this policy for your records and this policy can be available at any time if requested.

I understand that Telemedicine (also referred to as e-therapy, teletherapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemedicine. My rights to confidentiality with Telemedicine services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by me during the course of my therapy, therefore, is generally confidential, with the following exceptions:

- Mandatory reporting of child, elder, and dependent adult abuse.
- Any threats of violence I may make towards a reasonably identifiable person.
- If I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.
- If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

Therapeutic treatment for mental health, both in person and through Telemedicine services, has been found to be effective in treating a wide range of clients, individual results and responses to therapy may vary. By signing this form I also understand that results of any therapy, whether in person or through Telemedicine services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption occurs my therapist will call me at the number provided in my patient chart or at the beginning of session, if different.

I agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts. By signing this consent form I am acknowledging that I know how to contact my provider in case of a disruption and I know how to contact the crisis hotline (800)273-8255, call 911 or go to the nearest emergency room.

I consent to my therapist contacting the following individual(s) and/or the emergency contact listed in my patient chart and/or 911 in case of concern for my safety:

1. Name:_____ Relationship:_____ Phone:_____
2. Name:_____ Relationship:_____ Phone:_____

I understand that Telemedicine treatment for mental health is different from in-person therapy. I understand that if my therapist believes I would be better served by another form of therapeutic treatment or services, such as in-person treatment, I will be provided a referral to another therapist who can provide me with recommended services, such as in-person therapy.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telemedicine interaction to any other entities shall not occur without my explicit written consent. Mid Cities Counseling Center, PLLC also agree to under no circumstances take any personally identifiable images from the session or store any of these images on their own devices from Telemedicine sessions.

I also understand that my Telemedicine appointment time is reserved exclusively for me. In accordance with our Agreement for Service/Informed Consent, if you are unable to attend a scheduled appointment, you will be expected to pay a **$55.00** late cancellation fee unless you provide a 24 hours advance notice of cancellation. It is important to note that insurance companies **do not** provide reimbursement for cancelled sessions.

Similarly, if I am late to my scheduled session, I will receive my service for the remainder of my scheduled session time slot without refund.

In accordance with the American Telemedicine Association (ATA) I agree to have Telemedicine sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed at https://www.speedtest.net/. *These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.*

I understand that Telemedicine appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one present in the room. ***Also, due to licensing requirements I agree to be physically in the State of Texas during each Telemedicine visit.***

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Mid Cities Counseling Center, PLLC at (817) 888-8131.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Telemedicine Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemedicine Services via an online HIPAA compliant telemedicine platform DOXY.ME or TherapyAppointment.com with the clinician listed below:

Adult Client Name	Date of Birth	Signature	Date

Adult Client Name	Date of Birth	Signature	Date

Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor	Date

_____ _____

Therapist Signature Date