Dawn Nelson, LCSW-S, ACSW, SAP, CART

Patient Information

Name: _____ Phone: _____
Is it ok to leave call/leave message/text appointment reminders? Y N

If conjoint counseling, additional Client's Name: _____

Address: _____City: _____ State: ____ Zip: _____
E-mail Address: _____
(NEVER shared or sold), Okay to email for appointment reminders? Y N

Age: _____ Birth Date: _____ Marital: S M W D Other

If conjoint counseling, additional Client's Age: _____ Birth Date: _____

Name of Emergency Contact: _____Phone: _____

How were your referred to my office?

____ Psychology Today

____ Google

____ My website

___ Good Therapy

____ Other: _____

Family Medical Doctor (first and last name):
_____
Month and year of last physical: _____

Current Psychiatrist or Other Health Specialist:
_____
Month and year last seen: _____

Purpose of today's appointment:
_____
_____
_____

Previous counseling? ____ Yes ____ No If yes, when and was it helpful:
_____
_____
_____

Current Medications and Dosage:
_____
_____
_____

Previous Medications:
_____
_____
_____

AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of therapy and counseling care at the time of service. I understand that the therapist neither accepts insurance payments nor files my insurance; however, the therapist will provide a Superbill, if requested, for me to file for reimbursement. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable. I acknowledge a Good Faith Estimate (GFE) was provided within the new client paperwork packet.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE which is available in the office and on the website.

I agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

Patient's Signature: _____ Date: _____

Co-patient Signature (if seen together): _____ Date: _____

Parent/Guardian's Signature Authorizing Care: _____
Date: _____

Informed Consent for Counseling

Dawn Nelson, LCSW-S, ACSW, SAP, CART

I agree and understand that by initialing and signing the Electronic Signature Acknowledgment and Consent Form, all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required legally. _____ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law **when there is a reasonable suspicion of abuse or neglect of a child, elder, or disabled person or where a patient presents a danger to self or others**. _____**Initial**

DISCLOSURE MAY ALSO BE REQUIRED BY THE COURT. I will not voluntarily release records to any third party unless I am authorized to do so by all adult parties who were part of the family therapy, conjoint therapy or other treatment that involved more than one adult patient. However, a judge may issue a court order requiring the involuntary release of records. You will be informed before release is made. _____ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided as your emergency contact. _____ **Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: I do not file health insurance, however, if you choose to file, disclosure of confidential information may be required by your health insurance carrier or other third-party payer to process the claims. Only the minimum necessary information is communicated to the carrier. You are receiving a Good Faith Estimate attached to this consent form. _____ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for 5 years. As a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that

releasing such information might be harmful in any way. Upon your request, I will release information to any qualified medical personnel you specify. When more than one patient is involved in treatment, such as in cases of conjoint and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call. If I do not answer, I will return your call as soon as possible. If an emergency arises, call 911 or go to your nearest emergency room. _____ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. You must be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we fully expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe medications but will work in conjunction with physicians who do. _____ **Initial**

TREATMENT PLANS: At the end of our initial session, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used during your therapy or about the treatment plan, please ask. You also have the right to ask about other treatments for your condition and their risks and benefits. Reports generated for academic and other planning require additional fees.

_____ **Initial**

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept patients whom, in my opinion, I cannot help. In that case, I will give you referrals whom you can contact. If at any point during therapy you are non-compliant or no longer make payment, I will discuss the situation with you and may terminate treatment. In such a case, I will give you a licensed provider referral that may be of help to you. Upon your request, I will provide them with the essential information needed. You have the right to terminate therapy at any time. _____ **Initial**

COURT TESTIMONY: The therapist is not trained in expert testimony. Additional fees are payable before each court appearance and deposition should the therapist be required to testify; **the payment is for the time, not the testimony.** Each time the therapist is required to appear will require an additional fee even if it is under the same subpoena. Meetings, reports, and collaborative communication generated for legal cases also require additional fees.

_____Initial

DUTY TO WARN: Receiving counseling from a licensed professional is a confidential process. Your identity will not be revealed to anyone without your consent, HOWEVER: some courts have held that if a client intends to take harmful or dangerous action against another human being or against him/herself, a therapist has a Duty to Warn the intended victim and or state/local law enforcement. In cases of suspected child or elder abuse, I am required to notify appropriate state agencies. If you become involved in legal action, a court of law may subpoena my testimony or your records. I will, when expedient, notify you of these actions if they become necessary. **_____ Initial**

SOCIAL NETWORKING AND INTERNET SEARCHES: To protect client confidentiality, I do not accept friend requests from current or former patients on social networking sites, such as Facebook. For this same reason, patients may not communicate with me via any interactive or social networking web sites. **_____ Initial**

In the event of my death or incapacity, your records will be managed by the Texas State Board of Social Worker Examiners.

Texas State Board of Examiners of Social Work Examiners

1801 Congress Ave., Ste 7300, Austin, TX 78701
(512) 719-3521

I have read the above policies. I understand them and agree to comply. I agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

Client's Signature _____ Date _____

Co-Client's Signature (if applicable) _____ Date_____

Therapist's Signature _____Date _____

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Financial Information and Agreement

The fee for therapy is as follows:

Individual Therapy 50-minute Sessions, $200.00
Conjoint/Family 50-minute Sessions, $225.00
Other services listed below and on website

POLICIES AND PAYMENT:

APPOINTMENTS: Your appointment time is reserved exclusively for you. **Appointments cancelled with less than 24 hours' notice will be charged at the regular session rate.**

Payment for services is due at the time of service and is the responsibility of the client. Due to a wide variety of insurance policies, I cannot guarantee that, if you choose to file for reimbursement, your insurance company will reimburse you. You are ultimately responsible for payment. If you fall behind on payment, I have the right to discontinue services until payment for prior services is received. You agree to have an updated valid credit or debit card on file throughout active care.

RETURNED CHECKS will be charged a $25 fee.

I have read this page, received a copy, and agree to abide by the policies and procedures described. I, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

Client Signature: _____

Signature of Responsible Party (Financial Guarantor) if different:

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice and ability to read the HIPAA Notice on the clipboard in the waiting room or on the website; copies are available upon request.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

Good Faith Estimate:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. **Because you determine the number of sessions you attend, your good faith estimate is the number of sessions you decide upon multiplied by the rate of service.** The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Services:

90791 Diagnostic Session (First Individual Session), $200.00-225.00
90837 Individual Therapy 50-minute Sessions, Subsequent $200.00
90846 Family Psychotherapy without patient present, $225.00
90847 Family/Conjoint Psychotherapy with patient present, $225.00
90885 Diagnostic Interview Examination Including Report, $400.00
90853 Group Therapy, 50 minutes, $75.00
96116 Neurobehavioral Status Exam, 50 minutes, $200.00
90839 Psychotherapy for Crisis, 60 min, outside normal business hours, $300.00
Additional Psychological Tests, each, $50.00
90887 Collateral/Collaborative Meeting, 50 minutes, $250.00
Collaborative Communications, 15-minute increments, $25.00
Mediation, 50 minutes, $300.00
Parenting Facilitation, 50 minutes, $300.00
SAP Sessions (2), 120 minutes, $600.00
Court Testimony, Full Day Rate, $2500.00
Court Testimony, Half Day Rate, $1250.00
Preparation of Report for Court, $250.00
Preparation of Report for Academic Institutions, $100.00
Printed Copies of Treatment Records, $25.00
Travel Rate, per hour, $250.00
Late Cancel, less than 24-hour notice, $200.00-225.00
No Show Fee, $200.00-225.00