

New Patients of **Dr. Phillips,**

Welcome to the office of Dr. Jane Phillips. **Please complete and sign all attached documents.** If there are any changes in your insurance during the course of treatment, please advise me so that we can make billing changes as needed and avoid full financial liability.

Please read and sign the **cancellation policy agreement.**

Sessions will last **45-50 minutes.** I ask that you be on time. I will do my best to do the same. Please understand there are times when I may run behind schedule due to crisis or emergency situations.

Payment at the time of service will be requested in cash, check or credit card.

Please do not bring food or drink into the office area, due to the clinical issues of some of our patients. We want the environment to be comfortable for all patients.

On occasion, I may be called away for emergencies that will require me to make schedule changes with short notice. I will make every reasonable attempt to notify you of a schedule change. I will reschedule your appointment as soon as possible.

NEW CLIENT INFORMATION

Last Name of Client:	First Name:	Middle Name:
Address:	Date of Birth:	
City:	State:	Zip:
SS#:	Referred By:	
Home Phone: ()	OK to call and leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No; Best time to reach you?	
Cell Phone: ()	OK to call and leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No; Best time to reach you?	
Work Phone: ()	OK to call and leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No; Best time to reach you?	
Email Address (optional):	OK to leave confidential, detailed message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Person to be contacted in case of emergency:	Name:	
Relationship to you:	Contact Phone: ()	
Counselor Name: <input type="checkbox"/> Maria Villarreal, LPC <input type="checkbox"/> Lynn Schoenthal, LPC <input type="checkbox"/> Jane Phillips, PhD, LCSW		

INSURANCE INFORMATION

Last Name of Insured:	First Name:	Middle Name:
Date of Birth:	Soc Sec Num:	
Name of Insurance or EAP:	ID:	Authorization:

CONSENT FOR TREATMENT

I authorize and request that _____ (counselor name) carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

Signed by client: _____ **Date:** _____

CONFIDENTIALITY

All information between counselor and client is held in strict confidence by the counselor, with the following exceptions:

1. The client authorizes release of information, by signature, as specified on the Release of Information Form.
2. Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.
3. The client presents a physical danger to self or others.
4. An officer of a court of law legally requests information.
5. Child/elder abuse/neglect is suspected.

Please note that in the latter two cases, we are required, by law, to inform legal authorities so that protective measures can be taken.

I have read and understand the HIPPA policy statement provided to me by my counselor:

Signed by client: _____ **Date:** _____

MEDICAL HISTORY

Please list any prescription medications you are currently taking (name, dosage, frequency):

Please list any over-the-counter medications you are currently taking (name, dosage, frequency):

Please list any past or present medical conditions for which you have been treated:

Please list all known allergies:

MENTAL HEALTH HISTORY

Have you ever received psychiatric or psychological treatment of any kind before?

Yes No

If so, please provide information on the level of care:

In-patient Out-patient Both

Please indicate the reason for your previous treatment:

When and where were you in treatment?

How long were you in treatment?

HABITS AND SUBSTANCE USE

Current usage

Most ever used

Coffee (cups/day)

Cigarettes (packs/day)

Alcohol (please specify type)

Drugs (please specify type)

FAMILY HISTORY

Please describe any medical or mental health conditions of your spouse, parents, siblings and/or children:

Please indicate the level at which your issues are affecting your life in the following areas:

	No Affect	Little Affect	Some Affect	Much Affect	Significant Affect	Comments
Marriage/relationship						
Family						
Job/school performance						
Friendships						
Financial situation						
Physical health						
Sleeping habits						
Eating habits						
Anxiety level						
Mood						
Suicidal or self-harming thoughts						
Ability to concentrate						
Ability to manage anger						
Spirituality						

**Jane Phillips, Ph.D., LCSW
1109 North Cooper Street
Arlington, Texas 76011
(682) 225-6990**

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications:

After many years as a faculty member in the Department of Medical Education at the North Texas State University Health Science Center (formerly TCOM), I left the field to become a homemaker and full-time mother. When my youngest child entered kindergarten, I returned to school and earned an MSSW and a Ph.D. from the University of Texas at Arlington. I am licensed by the Texas State Board of Social Worker Examiners and am qualified to counsel all age groups through individual, couple, family, and/or group therapy.

My experience includes work as a private practitioner and as a hospital-based therapist. I have enjoyed the privilege of working with clients who have a wide range of personal and mental health issues including depression, anxiety, anger, suicidal thoughts, addictions, physical and sexual abuse recovery, relationship problems, and adjustment issues

Nature of Psychotherapy:

For individuals with distress in life, difficulties in interpersonal relationships, and life transition problems, psychotherapy provides a safe environment to address one's values, distorted thoughts, background issues, and temperament which might contribute to one's current feelings and behaviors. By developing an understanding of these factors, it is possible to gain a sense of control and make purposeful choices about how to live, thereby attaining greater life satisfaction.

For persons with specific issues they wish to conquer (e.g. depression, anxiety, posttraumatic symptoms, specific relationship issues, grief, etc), goals will be worked out with the therapist, and therapy will proceed to resolve those issues in a manner which meets the stated goals. The therapist and client will frequently evaluate progress, and adjust the course as needed.

Psychotherapy Relationship

During the time we work together, we will meet weekly, or as scheduled, sessions lasting approximately 50 minutes for individual adolescent or adult therapy. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any other way than in the professional context of the counseling sessions. You will best be served if our sessions concentrate exclusively on your goals and concerns.

Effects of Psychotherapy

At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights

Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client (or the parent of a client), you are in complete control and may end our counseling relationship at any time, although I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be helpful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know.

Cancellation

Your session is reserved for you. In the event that you will be unable to keep an appointment, please notify my office at least 24 hours in advance, so that someone else may utilize this time. In the absence of your notification, you will be billed a \$50 fee for the missed session. Also, if you are absent for two consecutive sessions, I may ask to terminate our counseling relationship, and provide you with appropriate referrals.

Referrals

I realize that I am not able to provide appropriate treatment for all of the conditions that clients may have. For this reason, you and / or I may believe that a referral is needed. In that case, I will provide you with some alternatives including programs and / or people who may be able to assist you. A verbal exploration of alternatives to counseling will also be made available to you at your request. You will be responsible for contacting and evaluating those referrals and / or alternatives.

Records and Confidentiality

All of our communication becomes part of the clinical record. Records are my property, but you have a right to the information within your record. Most communications are confidential, but the following limitations and exceptions do exist: (a) you provide me with your consent to release information; (b) I have reasonable suspicion that you are a threat to yourself or someone else; (c) you disclose abuse or neglect of a child, elderly, or disabled person; (d) you disclose sexual contact with another mental health professional; (e) I am ordered by the court to disclose information; (f) you involve me in a lawsuit and I need to release specific information in order to receive compensation for services rendered; or (h) I am otherwise required by law to release information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

Few experiences in life can be as enriching as the journey of self-discovery and personal transformation. My goal is to help you along your own path of progress as you become the person you desire to be.

By your signature below, you are indicating that you read and understood this statement, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify accuracy of this statement and acknowledge my commitment to conform to its specifications.

Printed Name of Client or Child

Date

Signature of Client or Legal Guardian

Signature of Client or Legal Guardian

Signature of Counselor

Offices of Jane Phillips, Ph.D., LCSW

HIPAA Compliance Standards

NOTICE OF PRIVACY PRACTICES

This Notice is effective on October 15, 2005

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

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area
- Have copies of the new Notice available upon request

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to medical information about you
- Describe how and where you may file a privacy related complaint

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about clients everyday. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you.

1. TREATMENT

We may use and disclose medical information about you to provide health care treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

2. PAYMENT

We may use and disclose medical information about you to obtain payment for health care services that you received. This means that we may use medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose medical information about you to others (such as insurers, and collection agencies). In some instances, we may disclose medical information about you to an insurance plan before you receive certain health care services because, for example, we may want to know whether the insurance plan will pay for a particular service.

3. HEALTH CARE OPERATIONS

We may use and disclose medical information about you in performing a variety of business activities that we call "health care operations." These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose medical information about you in performing the following activities.

- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other clients.
- Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

4. PERSONS INVOLVED IN YOUR CASE

We may use and disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the client is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the client is a minor. If the client is a minor, we may or may not be able to agree to your request.

5. REQUIRED BY LAW

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report known or suspected child abuse or neglect to the appropriate agencies. We will comply with those state laws and with all other applicable laws.

6. NATIONAL PRIORITY USES AND DISCLOSURES

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law.

- Threat to health or safety: We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- Public health activities: We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.

- Abuse, neglect or domestic violence: We may disclose medical information about you to a government authority if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- Health oversight activities: We may disclose medical information about you to a health oversight agency - which is basically an agency responsible for overseeing the health care system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- Court proceedings: We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- Law enforcement: We may disclose medical information about you to law enforcement official for specific law enforcement purposes. For example, we would disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- Coroners and others: We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- Workers' compensation: We may disclose medical information about you in order to comply with workers' compensation laws.
- Research organizations: We may disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- Certain government functions: We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activated and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. AUTHORIZATION

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the authorization - or signed permission-of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

I acknowledge receipt of this notice.

Client Name: _____

Date: _____

Signature: _____

Reason Given by Client for Refusing to Sign this Notice

Financial Policy

Effective November 1, 2011

I, _____, have requested services from Jane Phillips, PhD, LCSW and I agree to pay for services at the following rates and to abide by the terms outlined in the contract and the attached new patient information:

Evaluative Interview	50 minutes	\$150.00
Individual Therapy	45 minutes	\$105.00
Family or Couples' Therapy	45-50 minutes	\$150.00
Telephone communication	0-15 minutes	\$30.00
Report Preparation	0-15 minutes	\$30.00
Court Appearance	per hour	\$200.00
Group Psychotherapy	60-90 minutes	\$50.00
Email Communication	0 – 15 minutes	\$30.00
Other:	_____	

If it is necessary to have a session longer than 50 minutes, \$30 per additional 15 minutes will be charged. Your insurance company may not cover this amount. Payment for services rendered is the responsibility of the client and/or responsible party. All fees are due upon receipt of services unless prior arrangements have been made. We may file claims to your insurance company, but it is clearly understood by both the client and therapist that verification of benefits does not guarantee payment. Your insurance coverage is a contract between you and your insurance carrier. If you are part of a plan that has a contract with this therapist to render services at a contract rate, you will be responsible for paying any deductible and any co-payment established by the contract. It is your responsibility to know your co-pay, deductible, and number of sessions allowed each year, as well as any authorization numbers and sessions allowed. If the claim is paid at a different amount, the therapist will reimburse for any credits or require payments for any balances due.

Client initials: _____

It is the nature of therapy to devote an entire 45-50 minute session for you. This therapist has a full practice and there is often a waiting list for clients. Because of this, it is very important that you give at least 24 hours' notice in the event you need to cancel or re-schedule an appointment so another client can be scheduled at that time. In the event that you do not keep a scheduled appointment and fail to give 24 hour notice, you will be required to pay \$50.00 for each appointment that is a late cancellation (less than 24 hours' notice) or "no-show." Insurance companies will NOT pay for this. Late cancellations and "no shows" are very costly to a therapist's practice when only one person or family is seen per hour. In addition, services are not provided to others who are in need. Your treatment is my main priority and I hope you will be able to attend each scheduled appointment or re-schedule appointments allowing more than 24 hours notice. If you are more than 15 minutes late without a call stating you will be attending, you are considered a "no show" and will be responsible for payment.

Client initials: _____

If you are delinquent in the payment of your account, future appointments will be in jeopardy and no further reports will be generated; this includes EAP reports, court documents, letters of referral, etc. Acceptable methods of payment include cash, check, and credit card (Visa or MasterCard). Please note that if your check is returned for insufficient funds, the amount of the check, plus any other outstanding checks, plus a \$25.00 NSF fee will need to be paid immediately by cash or credit card. By signing below, you specifically authorize the credit card payment of any balances due according to this policy.

Client initials: _____

If you choose to join group therapy, you will be responsible for payment for the group session regardless of your attendance. Group size is limited and your joining reserves a place for you. Therefore, payment must be made to keep the space.

Client initials: _____

I have read and understood the terms of this agreement and by my signature agree to all terms contained herein.

Client Signature

Date

Jane Phillips, Ph.D., LCSW

Date