AUSTIN PSYCHOLOGICAL PRACTICE PLLC

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Informed Consent for Treatment

This form provides you, the patient/patient's guardian, with information that is additional to that detailed in the Texas Notice of Privacy Rights and it is subject to HIPAA preemptive analysis.

APPOINTMENTS: Appointments are times that are reserved for you. It is important that if circumstances arise which require you to change an appointment, I ask that you provide me with at least 24 hours notice. This will allow me to offer your time to another patient. **I charge a $75 fee for appointments not cancelled with at least 24 hours notice**. Fees for missed appointments are not billable to your insurance company. Time is valuable and if you continue to miss appointments without providing 24 hour-notice, we will discuss your commitment to treatment and possible termination of services.

COST FOR SERVICES: Co-payments and fees not covered by insurance are due at the time of service. I accept cash and check. I also accept most credit/debit/HSA cards. **If paying by card, a 3.5% processing fee will be applied to the charge.**

HEALTH INSURANCE: Many health insurance policies cover the services that I offer. Nevertheless, reimbursement varies considerably from company to company and from policy to policy. Also, most policies have co-payments and some have annual deductibles, or other limits. **It is up to you as the policyholder to read your policy carefully and be aware of what is, or is not, covered.** I recommend that you call your insurance company directly to ask about your benefits. I can provide you with the Current Procedural Terminology (CPT) codes. However, a quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of your insurance contract at time of service. **You are responsible for any fees/costs, such as co-pays, deductibles, and/or co-insurances, as stipulated by your insurance coverage.**

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. Please read the **Texas Notice of Privacy Rights** for more information.

CONFIDENTIALITY & TELEHEALTH: If psychological services are being conducted via a Telehealth platform, you recognize the possible limitations and possible vulnerabilities related to such online correspondence and confidentiality.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required, or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled, or when a patient's family members communicate to me that the patient presents a danger to self or others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. Otherwise, any information and reports pertaining to the service(s) provided to you will only be released to you, unless you complete an Authorization to Release/Obtain Records form. If you do complete an Authorization to Release/Obtain Records form, your records will be forwarded to the entity or entities you designate.

HEALTH INSURANCE, PAYMENTS, & CONFIDENTIALITY: Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. If required, only the minimum necessary information will be communicated to the insurance carrier. Please be advised that I have no control over, or knowledge of, what insurance companies do with the information that is submitted, or who has access to this information. In addition, if paying by check or credit/debit card, you acknowledge your name and other bank/account information will be shared with your respective payment processing company in order to process charges.

LITIGATION LIMITATION: Due to the nature of the evaluative and therapeutic processes, and the fact that it often involves 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(s), 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 unless otherwise agreed upon.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized persons and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and faxes that go through them. While my office server is secure, e-mails and e-faxes are not. It is always a possibility that e-faxes, texts, and emails can be sent erroneously to the wrong address and computers. Unencrypted email, e-faxes, or text provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the U.S. Post Office. My office server is equipped with a firewall, a virus protection, and a password. Please notify me if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, I will assume that you have made an informed decision, I will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or e-faxes for emergencies.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact, please leave a message at (512) 998-9806 or jason@austinpsychologicalpractice.com and your call or email will be returned as soon as possible. If an emergency situation arises, please call 911 or go to your nearest emergency room.

PAYMENTS & INSURANCE REIMBURSEMENT: Out-of-pocket patients are expected to pay $200.00 per 50-minute session at the beginning of each session unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, review of records, longer sessions, travel time, etc. may be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of evaluation/therapy regarding your ability to make timely payments. Patients who carry insurance should remember that professional services are rendered and charged to the patients and not to the insurance companies. Unless agreed upon differently, I will provide you with a copy of your receipt if you would like, which you can then submit to your insurance company for reimbursement, if you so choose. **Not all issues/conditions/problems, which are dealt with in psychotherapy or psychological evaluations are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I reserve the right to use legal or other means (courts, collection agencies, etc.) to obtain payment.**

SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept "friend" or related requests from current or former patients on social networking sites, such as Facebook, etc. I believe that adding patients as "friends" on these sites and/or communicating via such mediums is likely to compromise their privacy and confidentiality.

OTHER SERVICES: I am sometimes requested to complete paperwork or deliver services that are outside the scope of the medical record or coordination of care. Some examples include, but are not limited to disability questionnaires, accommodations paperwork for college/university/standardized testing, and school consultations/observations. While I am able to provide such services, they are not covered by insurance and are charged at an hourly rate of $275.

By signing below, you acknowledge that you have read, understand, and agree to comply with the above Office Policies and General Information, Agreement for Psychological Services, Informed Consent for Treatment, and have been offered a copy of the Texas Notice (Privacy Rights) form.

Patient's Name (please print) _____

Patient's or Guardian's Signature _____ **Date** _____

**If patient is a minor, or otherwise under legal guardianship/conservatorship, their legal guardian/conservator must complete the following as well:*

Guardian/Conservator's Name (please print) _____

Relationship to minor _____