Tiffany Smith Counseling, Inc.
1190 Parker Square
Flower Mound, TX 7502
(972) 899-1848
(072) 899-0235 Fax
www.heartyourfamily.com

Tiffany N. Smith, M.S., is a Licensed Professional Counselor Supervisor, Licensed Marriage and Family Therapist Supervisor, and National Certified Counselor. Additionally, she is an employee of Tiffany Smith Counseling, Inc.

Confidentiality: I am committed to confidentiality to the fullest extent allowed by Texas law. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies **without your permission.** Also, I am not required to inform you of my actions in this regard. These situations include but are not limited to the following: (a) If you threaten bodily harm or death to yourself or another person; (b) If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse (past or present), I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed of the court; (e) Any sexual improprieties by a former therapist must be reported to the AAMFT Ethics Committee, and (f) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different). The ethical code of marriage and family therapy prohibits dual relationships between clinician and patient and former patients. This means as our client we cannot meet with you for social occasions or be involved in any business activities with you other than providing psychotherapeutic services.

Risk to Treatment: The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, preserve personal safety, and to develop problem solving strategies to deal with current problems. Psychotherapy has both benefits and risks. Psychotherapy has been shown to produce significant improvements in emotional well-being, family and personal relationships, and work and school performance. Risks include experiencing uncomfortable levels of feelings like frustration, sadness, guilt, and loneliness. Although therapy can be a powerful life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities-exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure activities). We hope that you will see therapy through all of these phases.

Duty to Warn: In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name Telephone Number

_____

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

Address Telephone Number

_____

Appointments & Missed Appointment Policy:

Appointments: All sessions are scheduled by appointment only. My office hours are Monday-Thursdays from 8am-5pm. I consider evening appointments upon request. Additional after hours fees apply to appointments after 5pm. Appointment times are based upon the current fee schedule.

Set Repeated Appointments: Sometimes setting up a set weekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically tell me you would like to give it up. If two set appointments are missed, I will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times.

Missed Appointments: Appointments canceled with 24 hour notice incur **no** fees and every effort will be made to reschedule in a timely manner. If you are unable to keep a scheduled appointment, please contact the office at (214) 405-4030 at least 24 hours in advance. **Appointments missed or canceled with less than 24 hour notice will be charged $120.00.** It cannot be billed to an insurance carrier. I understand that emergencies and health problems do come up and I am willing to consider them when adequate notice is not given. However, No-shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not be considered. Additionally, if you are billing to a third-party, the individual whose policy is being billed, must be present in order for the session to be billed. Therefore, if that individual does not attend the session, you will be responsible for the full fee. Please note that the provider may terminate the counseling relationship after 2 missed appointments without calling to cancel 24 hours prior to your scheduled appointment. Additionally, any balance on the account for missed appointments must be paid prior to rescheduling an appointment.

Legal Proceedings: If you are currently involved or become involved with any legal proceedings, please inform me as soon as possible. It is important that we discuss how the proceedings might impact our work together. If legal actions occur, you will be responsible to pay me for the following **even if the subpoena is sent from the opposing side of the case;** (a) the time spent for travel to/from court at the rate of **$300.00 per hour**; (b) the time spent on preparing testimony, telephone conferences with attorneys, copying client records, reports, witness time, and depositions at the rate of **$300.00 per hour**; (c)the time spent on mediations and court appearances are billed at **$1,800 per half-day and $3,200 per full-day**. **All fees must be paid in full prior to any work being done on the legal case.**

Communication:

Telephone Communication: If I am available I will respond by cell phone after hours and between sessions for non -emergencies for up to 10 minutes w/o charge at: **214-405-4030.** That number will also accept confidential voice mail messages. Phone calls after 10 minutes in length will be billed at **$5.00 per minute.** Please note that telephone calls will be returned the next business day. If you find yourself facing

an emergency situation, please contact emergency services (911) immediately or go to your nearest hospital emergency room.

Text Messaging: This form of communication cannot ensure confidentiality and should be reserved for merely scheduling and/or canceling appointments.

Electronic Communication: When I am available, I will respond to email communication. However, I cannot ensure confidentiality of any correspondence sent via email and cannot be responsible for breaches in confidentiality resulting from someone getting your password or having access to your account. Therefore email communication should be reserved merely for scheduling and/or canceling appointments. I will attempt to try to respond to emails within two business days.

Records and Administrative Services: If you request it, any part of your record in the files can be released to any person or agency you designate. These requests must be made in writing and allow 30 days to process. There is a **$100 fee** to obtain a copy of your client record. Payment in the amount of **$200 per hour** will be charged for administrative services beyond the scope of the therapy sessions with a minimum of 30 minutes to complete a service. These services include but are not limited to: (a) consultation with other professionals, (b) preparation of reports or correspondence, (c) phone calls lasting over 10 minutes.

Incapacitation/death: I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice.

Discontinuing Treatment/Complaints: It is also important to understand that you are free to discontinue treatment at any time and agree to notify me immediately so that I may provide you with referrals for continued care. If at any time you wish to file a formal complaint regarding my counseling services, please contact the Texas State Board of Examiners of Professional Counselors and/or Texas State Board of Examiners of Marriage and Family Therapists, Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369; 1-800-942-5540. Additionally, we have the right to terminate your treatment at any time. Some of the reasons include but are not limited to: boundary violations, noncompliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided a referral source for another psychotherapy professional or agency.

Consent to Treatment:

*1. I agree to enter into therapy with **Tiffany Smith, M.S.** I have received a fee schedule and I agree to pay for services rendered with payment due at the conclusion of each session and no balance will be carried. I understand that if I am seeking reimbursement from a Third- Party Payor, I am financially responsible for all services rendered and agree to pay for claims denied by the third-party payor. I understand that if I am late to a session, the length of that session may be shortened, and I agree to pay for a full session. I understand there are additional fees for appointments after 5pm and on weekends that are my financial responsibility and not subject to a third-party payor.*

2. I understand that I can leave therapy at any time. I am contracting only to financially pay for completed therapy sessions.

*3. A full **24 hour notice** is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the **$120.00 No-Show Fee**. I understand that this will be my responsibility not that of the third-party payor as they do not reimburse for missed appointments.*

*4. If I miss an appointment without prior notice and do not contact this office with **10 business days** following the missed appointment, then I understand my treatment with my therapist will have terminated and my file will be closed.*

5. I understand that the therapist has the right to see legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist has the right to use confidential information to establish the fee claim.

6. You acknowledge that you have received and understand the Notice of Privacy Practices for this office.

Signed:_____ Date:_____
Signed:_____ Date:_____
Therapist:_____ Date:_____

IF A CLIENT IS A MINOR: I give permission for this minor child(ren) to receive counseling without a parent or guardian present. I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility. I also agree that should my legal authority be revoked, I will inform my therapist immediately.

Name of Child:_____ DOB:_____
Name of Child:_____ DOB:_____
Name of Child:_____ DOB:_____
Name of Parent or Legal Guardian:_____
Signed:_____ Date:_____
Therapist:_____ Date:_____

Fees and Payment:

Clients or Parents/Guardians are responsible for payment for all services rendered. Payment or Co-Payment is due by the end of each session. Payment may be made with cash, check, or credit card. A completed receipt will be provided at the end of each session documenting the service delivered and fees paid. Please also be aware that there is a **$75 fee** for any returned/canceled checks and credit card charge backs/declines. Except where we have a contractual agreement with a Third-Party Payor, our fees are as follows:

Diagnostic Evaluation/ Initial Consultation $150.00
Adult Individual Psychotherapy (40 Minutes) $100.00
Child Individual Psychotherapy (40 Minutes) $120.00
Adult Individual Psychotherapy (55 Minutes) $140.00
Child Individual Psychotherapy (55 Minutes) $160.00
Family Psychotherapy (40 Minutes) $120.00
Extended Family Psychotherapy (55 Minutes) $160.00
After Hours Appointment Fee $20

Third Party Payment: We will make fee adjustments according to our contract with an insurance carrier. Any contractually agreed charges that are not paid are the responsibility of the client or responsible party. If we do not have a contract, our full fees will be charged. **Anything not paid for by the insurance company is charged to the client or responsible party.** Please be aware that by filing through a Third Party whom we have a contract, they only reimburse for specific services rendered. Therefore your appointment times and treatment may be limited to what your policy allows. Any fees requested outside of what your policy pays is subject to your own financial responsibility. We will file a claim for the services rendered to your insurance company that we are a provider. **Failure on the part of your insurance company to honor any payment agreement, process an authorization request or claim, add unexpected limitations to your policy, deny payment due to failure for you to obtain preauthorization requirements, denial of payment of any and all services you received regardless of your policy limitations, etc. leaves you, responsible for any unpaid charges.** Additionally, if a third party, such as an insurance company, is paying for part of your bill, they may require that we provide them with a psychiatric diagnosis in order to be paid. They may request information regarding treatment plans and progress made during treatment. We will be happy to discuss with you any information that we share with your insurance provider. If we do not take your insurance, we will be happy to provide a receipt to you to submit to your insurance company as an out-of-network provider. Additionally, your insurance company may limit the number of sessions you have available or deny coverage for the services you are seeking help for (such as couples or family counseling). So please verify your benefits before your first appointment as you are financially responsible for any and all unpaid charges for services rendered.

Medical Release Statement

I authorize the release of any clinical or other information necessary to process my insurance claim to third payors of my benefits.

Signature/Date: _____

Printed Name: _____

By signing this form, I acknowledge and understand these policies.

_____

Date

Credit Card Information

Please provide your credit card information if you plan use to make payments on your account or for no-shows and missed appointments without giving prior notice:
Type of Credit Card (circle): American Express/ Visa/ Master Card/ Discover
Name as printed on card: _____
Credit Card Number: _____
Expiration Date: _____
3-4 Digit Security Code on Back of Card: _____
Billing address for credit card:
_____
_____City _____State _____Zip Code
By my signature below, I grant ***Tiffany Smith Counseling, Inc.*** my permission to charge the account described above.
Signature Date: _____
Printed Name: _____
By my signature below, I grant ***Tiffany Smith Counseling, Inc.*** permission to charge the account described above for any outstanding balance that is 60 days past due.
Signature/Date: _____

NOTICE OF PRIVACY PRACTICES
Tiffany Smith Counseling, Inc.

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Tiffany Smith Counseling, Inc. is required by law to abide by the terms of this *Notice Of Privacy Practices*, allow you to review this *Notice* prior to granting consent, and notify you of changes/revisions to this *Notice*. If you believe your privacy rights have been violated, you may submit a written complaint to Tiffany Smith Counseling, Inc. or to the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Tiffany Smith Counseling, Inc. will not retaliate against you in any way for filing a complaint with him, or with the Secretary.

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your healthcare record is the physical property of Tiffany Smith Counseling, Inc., but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record. Tiffany Smith Counseling, Inc.; however, has the right to use and disclose the information contained in your healthcare record in the process of providing treatment, receiving payment and performing other regular health operations such as:

• Documenting and describing the care you received for legal purposes
• Communicating with other healthcare providers who may be involved in your case
• Educating health care professionals
• Evaluating and improving the care you receive and the outcomes achieved
• Billing and verification of services provided to you

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Tiffany Smith Counseling, Inc. Tiffany Smith Counseling, Inc. is required by law to maintain privacy and confidentiality of your health information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you if Tiffany Smith Counseling, Inc. is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice. Examples of disclosure of your PHI and your rights concerning PHI are continued below. If you have questions or would like additional information, contact Tiffany Smith the privacy officer for Tiffany Smith Counseling, Inc. at 214-405-4030.

EXAMPLES OF DISCLOSURE OF YOUR PHI

Healthcare delivery and treatment: Information obtained from you by Tiffany Smith Counseling, Inc. is documented in your record and used for the assessment, evaluation, diagnosis and treatment of your health conditions). This information is provided to other healthcare professionals, such as other physicians, specialists, hospital based providers and/or other healthcare providers following your treatment by Tiffany Smith Counseling, Inc. This information would only be provided to these individuals by your expressed consent.

Billing and Payment: Your PHI is utilized to justify the level of care delivered to you and the charged incurred for the services. This information generally accompanies the bill and is sent to our payers.
Other healthcare operations: Tiffany Smith Counseling, Inc. may disclose your PHI to other individuals and businesses in order for him to perform his day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for billing and claims management. These individuals are held to the same standard of privacy and confidentiality as Tiffany Smith Counseling, Inc.
Reminders and Treatment: Tiffany Smith Counseling, Inc. may contact you to provide you with information she feels is useful or helpful to you, based on your PHI. For example, she may contact you to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Tiffany Smith Counseling, Inc. has already taken action in reliance on your prior authorization. The only exception to this would be under circumstances that are life-threatening or an emergency, such as an individual being acutely suicidal or in some other way in extreme danger. Not all information provided by you to Tiffany Smith Counseling, Inc. will be recorded in a healthcare record, only that information considered by her to be critical to providing for your care. Other information regarding personal matters in your private life and affairs will not be made part of a healthcare record document.

YOUR RIGHTS CONCERNING PHI - Except as otherwise provided by law, you have a right to:

- receive a paper copy of this *Notice of Privacy Practices* if you have agreed to receive it electronically;
- receive a confidential communications of PHI if a request is submitted to Tiffany Smith Counseling, Inc. in writing.
- inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;
- ask Tiffany Smith Counseling, Inc. to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (Tiffany Smith Counseling, Inc. is not required to change the information if she deems it to be accurate);
- receive an accounting of disclosures of PHI (a list of the disclosures made by Tiffany Smith Counseling, Inc. about you for reasons other than treatment, payment or healthcare operations); and
- request that Tiffany Smith Counseling, Inc. restrict uses or disclosures of your PHI. Though Tiffany Smith Counseling, Inc. is not required to agree to a restriction, to the extent that it does agree with your request, Tiffany Smith Counseling, Inc. may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

E*ffective Date: 01/10*

Insurance Information

_____ I DO NOT wish to file with my health insurance carrier at this time. I understand that any sessions completed will not be billed to an insurance provider and that any sessions completed will not be able to be filed. Should I wish to file with my insurance carrier in the future, I will notify the office to discuss benefits and payment arrangements.

_____ I DO wish to file with my health insurance carrier at this time. I understand that I am financially responsible for any and all unpaid services rendered. I agree to notify the office should I have any changes in insurance carriers or benefits and it is my responsibility to verify benefits for services rendered.

Patient's Name: First_____ Last_____ MI_____
Patient's Address_____
Patient's Birth Date_____Patient's SSN:_____
Primary Insurance
Insured is: Self___ Spouse____ Child____ Parent____ Other_____
Insured's Name: First_____ Last_____ MI_____
Insured's Address_____
Insured's Birth Date_____Insured's SSN:_____
Insurance Company_____
Policy Number_____ Group Number_____
Insurance Address_____
Insurance Phone Number _____
Name of Employer:_____
Address:_____
Telephone:_____
Occupation:_____
WE DO NOT FILE SECONDARY INSURANCE.
PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR FIRST SESSION

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RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize Tiffany Smith Counseling, Inc. to disclose or receive my protected health information including: psychotherapy notes, progress notes, case notes, billing and scheduling information, assessment and psychological testing reports, physical healthcare treatment records, and psychotherapy treatment and progress.

PLEASE CHECK

____School: _____

Contact person _____Phone#_____

____Medical Doctor: _____

Address: _____

_____Phone#_____

____Previous Therapist: _____

Address: _____

_____Phone#_____

____Other: _____

Address: _____

_____Phone#_____

This release shall remain in effect until such time as it is revoked in writing by me.

_____ _____
Signature of Client/Legal Representative Date of signature

_____ _____
Name of Client/Legal Representative Client's Date of Birth

_____ _____
Expiration Date of Consent Client's Social Security No.

INTAKE FORM

Date of First Appointment: _____ Email _____

Name: _____
Last *First* *Middle*

_____
Address

_____
City *State* *Zip Code*

Phone numbers: _____ _____ _____
Home *Cell* *Work*

May I leave a message for you at home? Y / N
May I leave a message for you at work? Y/ N
May I leave a message for you on your cell? Y/ N
May I contact you via email? Y/ N
Please list the email address that you wish to be contacted at (we do not release email addresses):
_____

Race/Ethnicity:_____

Relationship Status: Married____ Single___ Divorced____ Widowed____
Cohabitating____ Other_____

Sexual Orientation: _____

Education Level: Elementary /Middle School_____ High School_____ Some college_____
Bachelor's Degree_____ Graduate Degree_____ Other _____

Occupation: _____ Employer: _____
Employer address:_____

Household Members:

Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____

Briefly describe your reason for seeking counseling: _____
_____
_____

What goals do you hope to achieve by attending counseling?_____
_____
_____

List any major health problem for which you currently receive treatment:
_____

Medication:	Dosage:	Treatment of Symptoms:	Length of Use of Medication:
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently involved in an exercise regimen?
Yes____ No_____ If yes please list the type of exercise and amount per week

_____

Current hobbies/ personal interests:_____

Current religious/spiritual beliefs:_____

Please answer the following as it applies to you:

Do you currently drink alcohol and if so please state the amount consumed per day/week? _____

Do you currently smoke and if so please state the amount consumed per day/week?_____

Do you currently use any controlled substances and if so please state the amount consumed per day/week?_____

Are you currently or have you in the past been involved in any criminal activity?_____

How many times per week does your family sit down for meals together?
_____

Have you or any family member ever struggled with any of the following symptoms/behaviors? And if so, please name the family member and date it began/ended.

Eating Disorders:
Drugs/Alcohol :
Fighting/Physical Agression:
Cutting/Self-Harm:
Suicidal thoughts/attempts:
Homicidal thoughts:
Running away:
Truancy:
Depression:
Anxiety:
Gang/criminal activity:
CPS Involvement:
Domestic Violence:
Physical/Sexual Abuse:

Is there anything else your therapist may find helpful in knowing in regards to the treatment you are seeking for your family? _____
_____

Have you ever previously attended therapy or received counseling services of any kind? Yes____ No_____ If yes please list the type of therapy you received_____

Did you find treatment helpful?_____
Previous therapist: _____

Reason treatment terminated?_____

Previous Psychiatric Hospitalizations?_____

Treatment and Diagnosis Rendered?_____

Do you anticipate being involved in a lawsuit in the near future? Y/ N
If yes, please explain_____
_____
Have you ever been a party to a lawsuit? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:
_____
_____

Have you ever filed a complaint with a licensing or regulatory authority? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:

_____

_____

How did you hear about us?_____

_____

Customer Satisfaction Survey: Upon discharge we will ask you to complete a client satisfaction survey. The survey is anonomous and confidential and is used so that we can improve the quality of our services. Please provide us with your email address. We do not release email addresses to third parties.

I would like the survey sent to my email address at:

_____

Would you like to receive our e-newsletter? Yes/ No
(We do not release email addresses to third parties)