

Heritage Behavioral Health Center
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EMDRIA Approved Consultant

CLIENT INFORMATION, POLICIES AND CONSENT FORM

By making your first appointment you have already made progress. Deciding to begin or to resume therapy shows your courage and willingness to take risks in order to improve your life. Therapy can be a rewarding and life changing process for those who dare to risk. It is important that you be aware, however, that sometimes therapy causes us to feel worse before we feel better, simply because we are focusing on and heightening our consciousness about issues that are not always pleasant, until we discover the necessary insights or appropriate solutions. It is my hope that I can assist you in finding those solutions with the understanding that it is a joint effort between us. I look forward to working with you and hope I can assist you in reaching whatever goals you set. Effective psychotherapy is built from good working relationships, rapport and require mutual understanding. It is in both of our interests to convey to you the policies and procedures I use in my practice; it is your right to be an informed consumer; I am willing to discuss any questions or problems you may have.

RELATIONSHIP: I care about helping you reach your therapeutic goals and/or personal growth. In order to accomplish this, a professional and therapeutic relationship will always be maintained. Mixing personal and professional relationships undermine the effectiveness of therapy. Moreover, dual relationships with clients violate my professional code of ethics. This professional relationship boundary extends to any office personnel who work at Heritage Behavioral Health Center.

CONFIDENTIALITY: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of an elderly or disabled person, abuse of patients in mental health facilities, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist has a duty to warn or disclose, fee disputes between the therapist and the client and in a negligence suit or licensing board complaint brought by the client against the therapist. If you have any questions regarding confidentiality you should bring them to the attention of the therapist. By signing this information and consent form you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law, the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. The billing professional will also convey demographic and diagnostic information for claims and collection purposes only. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. Your employer will **not** know you are coming to therapy just because you utilize benefits provided by that company, unless you choose to tell them. It is also the policy of this office to not confirm or deny that you are a client here, including appointment times, etc., even to spouses or family members, without your permission.

For some clients there is a concern that by using insurance, a **diagnosis** considered by the American Psychiatric Association to be a "mental illness", will be generated. Concerns regarding future insurance coverage and/or job applications have been expressed. If this is a concern for you, you may be more comfortable maintaining more privacy by paying for said treatment out of pocket. If you'd like to discuss this option, let the office coordinator or your therapist know. Payment plans can be determined that make therapy affordable for you.

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 any person in a position to prevent harm to myself or another person, including the person in danger, and to contact the following persons in addition to medical and/or law enforcement personnel:

NAME

TELEPHONE NUMBER

CHILDCARE: We are unable to provide child care services during your therapy session. Please do not bring young children unless you provide adult supervision.

APPOINTMENTS are usually scheduled once a week and last approximately 45-60 minutes. Once progress has begun, they can be less frequent. More frequent sessions or intensive outpatient schedules are possible depending upon the circumstances. If you need to reschedule or cancel an appointment, please call the office at (817) 488.9697 and let us know about your schedule change or cancellation. Broken appointments are a loss to everyone. Messages can be left on the voicemail system 24 hours a day. **It is important that changes be made well in advance of your scheduled time, preferably 24 hours or more, whenever possible; a missed appointment or an appointment canceled without adequate time to fill your appointment hour will result in a \$75.00 charge.**

TRAUMA RESPONSE: I am on some contracts which ask me to respond to critical incident traumas which can, and usually do, effect worksites and communities. As you know, crises which result in the traumatization of individuals and groups usually occur without warning and are rarely convenient. Given the nature of this type of expertise, the call to respond may interfere with my regular hours of seeing clients. Whenever the need to cancel & reschedule clients due to this type of emergency arises, you will be contacted as soon as possible (ASAP). The situation will be briefly explained and you will be asked to reschedule your appointment. I am sensitive to not rescheduling my clients unless it is necessary and therefore every effort will be made to get affected clients in for a rescheduled appointment within the same week or very shortly thereafter. If you think the possibility of being rescheduled will be too disruptive or upsetting to you, please let the office coordinator or me know before or during your first appointment.

THE FEE SCHEDULE

Diagnostic & Evaluation Session (1st Visit – 60 min)..... \$150.00
Regular Office Visits (45-60 minutes)\$115.00-\$130.00
Outside Office Work per hour (inpatient visits, court, etc.).....\$125.00
Late Cancel < 24 Hrs or No Show Fee's \$ 75.00

(This is **not** a forensic practice, but occasionally we cannot escape the snare of subpoenas and required court testimony. All preparation time, records reproduction, travel time, mileage, time away from the practice will be your responsibility, since you are the client - REGARDLESS of who is requesting records or court appearance related to you; a minimum of two hours will be billed).

Written Reports (Insurance companies, supervisors, etc.)..Pro-rated at..... \$75.00/hour
Records Reproduction..... \$20.-\$75.00
Travel Time..... \$65.00/hour
Mileage..... .30/mile

PAYMENT OF FEES: Required fees and co-pays are payable at the beginning of each session with Visa, Mastercard, Discover or AMC Credit or Debit, Check or Cash. We will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions and claim filing requirements. However, if you are using a managed care plan, you will be expected to pay your copay or deductible at the beginning of the session. Due to the increasing problem

with obtaining accurate benefit information from managed care companies, it is sometimes necessary for us to collect the full contract rate for the first couple sessions until we receive the first insurance Explanation of Benefits (EOB) & payment. Once benefits are established, we will apply any overage to future copayments, or you can be reimbursed for any overpayment. If you are using your insurance benefits, Heritage Behavioral Health Center will file claims if requested. However, we do not file secondary insurance. If you are not using a Managed Care/PPO/HMO plan and want to file your own claim, you will be expected to make the full payment and a superbill will be given for you. **In order to take full advantage of your session time, it is requested that your check be prepared prior to beginning the session. This also helps to expedite the re-scheduling process.** Monthly payment arrangements are possible for those who have already established a record of paying as they go.

EMERGENCIES may occur. Please call the office and express the nature and urgency of the emergency on the confidential office voicemail or to the office manager, if one is available, and she will schedule you to get in ASAP or give other appropriate options. Due to the fact that clients are scheduled one after another, it is not always possible to get a message or return a call immediately, but all effort is made to do so in emergency situations. If an after hour or weekend emergency occurs, the emergency phone number is given on the Heritage Behavioral Health Center voice mail at (817) 488-9697. I will call you back as promptly as I can. If the urgency of your need is such that you cannot wait for the phone call to be returned, you may need to contact the Crisis Intervention 24-Hr Hotline at (817) 927-5544 in Tarrant Co. and (214) 233-2233 for adults in Dallas Co. or (214) 233-TEEN for teenagers, call your insurance company for the next higher level of care coverage, call 911, or have someone take you to the nearest hospital emergency room for the necessary help. When I am out of town, all clients currently being seen will be advised and an on-call therapist's name will be cited on the office voice mail to call.

DEATH OR INCAPACITY OF THE THERAPIST - In the unfortunate event that I become unable to continue to see you due to disability or death, by your signature below you are giving permission to the office coordinator and another licensed therapist to briefly review your file for the purpose of notifying you and possibly transferring you to another appropriate therapist? If this is unacceptable for any reason, notify the office coordinator or therapist before signing this document.

Also, in the unfortunate event of your death, what becomes of your file may become an issue. It is possible that several people will want us to release information from it or even turn it over to them. It is in your best interest, as well as that of your family, and the professionals within this office, for you to tell us in advance to whom you **would** permit us to release information, **without** having a court order. You can choose to not give permission to anyone but if you want to permit one or more people, please list them on the following lines by full name and relationship, i.e. spouse, grown son/daughter, sibling, etc.

1. _____ Relationship _____
2. _____ Relationship _____

I have read and understand the procedures specified above by Heritage Behavioral Health Center.

Signature - Client

Date

Witness

Date

Therapist

Date