Amanda Keith, LCSW
Licensed Clinical Social Worker

100 Chestnut St suite 101
Abilene, Texas 79602

POLICIES & PROCEDURES

Please Read Carefully!

FEE SCHEDULE

The usual fee for the first session is $185.00, after which the basic fee for other sessions is $130.00 for 50 minutes. Longer or shorter sessions are prorated from this basic fee. Fees for psychological testing are based on time spent with the client plus time required for scoring and interpreting test data. We accept insurance assignment of benefits. We will accept your insurance deductible amount/copay at the time of service and will claim the insurance for you.

Fees for court appearance, whether you or your attorney requests it, or if I am subpoenaed, are $100.00 per hour. You will be responsible for all my time; including time for driving to court, waiting to testify, giving testimony, as well as preparation and/or research time that is required. Payment is required in advance. Insurance companies do not cover court preparation time and court appearances.

PAYMENT METHOD

Payment is requested before your session begins and may be made by check or cash.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

If you are unable to keep an appointment, please notify us immediately. If you do not call at least 24 hours before the appointment, you will be charged for the entire session.

RESPONSIBILITY

The client (or referring parent in the case of minors) is considered responsible for payment of professional services. In the case of divorced parents, we ask the parent bringing the child to pay the fees and then they be reimbursed by the parent not present. If there is ever a failure to pay an outstanding balance, we reserve the right to employ a collection agency and furnish them with information in order to collect.

You are encouraged to ask any questions you may have at any time including before you sign this form. Your signature below indicates that you understand and will comply with the above policies and procedures of Texas Family Institute. **Anyone age eighteen or older who participates in therapy needs to sign below:**

Signature: ______________________________________ Date: _________________

Agreed upon fee: ________

I will pay today by: _____ Cash _____ Check ____ Credit/Debit

CONFIDENTIALITY

Your right to confidentiality is protected by federal regulations and rules and regulations of the therapist's professional licensing boards. What you and the counselor discuss is strictly private unless you sign a Release of Information form asking us to disclose specific information to another individual or authority.

There are exceptions to this policy. Confidentiality may be broken and the appropriate individuals or authorities notified if:

1. I learn that you are a serious threat to yourself or others; or
2. I learn that a child or elderly person has been abused in the past or suspect that a child or elderly person may be abused in the future; or
3. A federal or state court brings a case to the judicial system concerning a client.

The above situations rarely happen, but it is important that you understand your rights to privacy and the limits of those rights. If you have any questions regarding this policy, please ask your counselor.

I have read and understand the above statement:

__________________________________ ______________________
Signature Date

MANAGED CARE/EAP/HMO CLIENTS: Some managed care/EAP/HMO companies providing insurance coverage have limits to the dollar and/or number of visits that they will allow the therapist to see you and pay for those services. If you choose to go beyond those benefits you will be responsible for any charges incurred. Feel free to discuss this with your therapist. Your signature below indicates your understanding of the limitations and your financial responsibility.

__________________________________ ______________________
Signature Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans to:

Amanda Keith, LCSW

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

__________________________________ ______________________
Signature Date

Statement of Understanding Regarding Custody Paperwork

Childs Name: ______________________________________ **Date of Birth**: _______________________

In accordance with the newest standards of care your therapist is required to have the most current copy of your child's custody papers on file. By signing the statement of understanding you as the parent with primary (Custodial) custody are assuring your therapist that the documents you provide are in fact the current copies of your child's custody orders.

Signature of Parent/Guardian/Client Representative: ____

Description of Authority to Act for Individual: _______________________**Date**: ___________________

If your orders **state both parents** have rights to know about appointments, speak with the child's counselor/Therapist, and have access to notes. we will expect you to inform the other parent of appointments and who the counselor/therapist is they will be seeing **before** they come in for the first appointment.

By signing you are agreeing that you understand your counselor/therapist is going to abide by the custody orders and you will give them the information needed to fulfill the custody orders. (other parent contact information)

Signature of Parent/Guardian/Client Representative: ____

Description of Authority to Act for Individual: _______________________**Date**: __________________

CLIENT REGISTRATION INFORMATION

DATE OF FIRST VISIT: _________

LAST NAME:___________________ FIRST (OR PREFERRED): ______________________

DATE OF BIRTH: ___________ Sex (F/M): ____ MARITAL STATUS: __________________

ADDRESS: ____

CITY:_________________________________ STATE: ___________ ZIP: ________________

		May Call:	May Leave Message:
CELL PHONE(S):	_________________	Y / N	Y / N
	_________________	Y / N	Y / N
HOME PHONE:	_________________	Y / N	Y / N
WORK PHONE:	_________________	Y / N	Y / N

Please indicate which number is the primary number: CELL ___ HOME ___ WORK ___

++++++++++++++ OTHER FAMILY MEMBERS LIVING AT HOME ++++++++++++++

NAME	DATE OF BIRTH	RELATIONSHIP (to you)

EMERGENCY CONTACT _____________________________ _________________________________
Name Phone Number

____
Address City State Zip

WHO REFERRED YOU TO OUR OFFICE? _____________________________________

(CONTINUED ON NEXT PAGE)

Personal Physician________________________________ Office Number _____________________

Please list any medications you are currently taking:

Name	Reason	Dosage	Frequency	From → To

Which doctor is prescribing these medications?____

Do we have permission to contact your doctor for consultation regarding your medications and counseling progress? ____Yes _____No

List current medical conditions (not referred to above):

List past medical conditions including hospitalizations:

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes / No
If you have, please explain (include dates, diagnosis, goals, and response to treatment):

Briefly describe your reason(s) for seeking help:

Please give marital history: (if applicable)

1st marriage: Years _________ children & ages ____________________________________

2nd marriage: Years _________ children & ages ____________________________________

3rd marriage: Years _________ children & ages ____________________________________

Briefly describe your current marital relationship: (if applicable)

Client Consent for Use and Disclosure
of Protected Health Information
(Permission to Treat)
Amanda Keith, LCSW

I, ____,
Name of Client

hereby give my consent for Amanda Keith to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). By signing this form, I agree to let you use and disclose my information to carry out my treatment and/or arrange for payment of treatment and/or consult with other providers about my treatment.

The Notice of Privacy Practices explains in more detail how you can use and disclose my information. I have the right to review the NPP prior to signing this document. Please read it before you sign below.

I may request that you restrict how you use and disclose my PHI to carry out my TPO; however, Amanda Keith is not required to agree to my request, but if she does, it is bound by this agreement. I may revoke my consent (in writing) except to the extent that disclosures have already been made in reliance on my prior consent. **If I do not sign this consent form or later revoke it, Amanda Keith may decline to provide treatment to me**.

Amanda Keith reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Stephanie Paschal, at 100 Chestnut suite 101 Abilene, Texas 79602.

_________________________________ _________________________________
Signature of Client/Parent/Guardian Date

Client's Name____________________ Client's Date of Birth________________________

____
Print Name of Client/Parent/Guardian

Date of NPP ______Copy Given to Client

Notice of Privacy Practices

Please review it carefully
This notice describes how medical information about you may be used and disclosed.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions and providing treatment. For example, results of tests will be available in your medical record to all health professionals who may provide treatment. Or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as insurers. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations: Your health information may be used as necessary to support the day-to-day activities and management of Texas Family Institute counseling practice. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, to comply with mandated reporting and as court ordered.

Other Uses and Disclosures Require Your Authorization: Disclosures of your health information or its use for any purpose other than those listed above required your specific written authorization. If you change your mind after authorizing a use and disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Reminders: your health information will be used by our staff to provide appointment reminders.

Information about Treatment: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These Include:
*The right to request restriction on the use and disclosure of your protected health information
*The right to receive confidential communication concerning your medical condition and treatment.
*The right to inspect and copy your protected health information.
*The right to amend or submit corrections to your protected health information.
*The right to receive an accounting of how and to whom your protected health information has been disclosed.
*The right to receive a printed copy of this notice.

Texas Family Institute duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests To Inspect Protected Health Information: You may generally inspect your protected health information that we maintain about you. As permitted by federal regulation, any request to inspect protected health information must be submitted in writing. You may obtain a form to request access to your records by contacting: Suzanne Perkins. Your written request will be reviewed and will generally be approved, unless there are legal or medical reasons to deny the request. You will be timely notified.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to Stephanie Paschal

If you believe that your privacy rights have been violated, you should call the complaint to our attention by sending a letter describing the cause of your concern to the same address. We make every effort to meet the requirements of the law. You will not be penalized or otherwise retaliated against by submitting a complaint. The name and address of our staff member you may contact for further information concerning our privacy practices is:

Stephanie Paschal
100 Chestnut suite 101
Abilene, TX 79602

I have received a copy of information pamphlet entitles “Notice of Privacy Practices” from Texas Family Institute

I have read or will read the information contained in this brochure concerning my health information, its uses and disclosure
my rights as a client of this behavioral mental health counseling practice and the clinic’s responsibilities. If I have any questions I may address them with the manager of the practice.

I acknowledge the receipt of this information.

____
DATE

____
Client Signature

____
Staff Signature

Additional Demographic Information

Optional
(information to be used for grant opportunities)

Parent/Guardian: ________________________________ Client: _________________________________

Number of people living in home: _______ Number of Dependents: _______

Monthly Income per household: ____________ Annual Income per Household: __________________

Married: ______ Single: ______ Divorced: _____ Separated: _____ Primary Custodial Parent: ________

Employed: _______ Student: _______ Retired: ________ Disabled: ________

Ethnicity: ____________________________________ Race: _______________________________

We want to thank you for providing this information. It is pure voluntary and any information gathered is to be used for grant opportunities to better assist the communities mental and behavioral health needs of Abilene and the surrounding areas residents. Providing this information could help us form classes / programs / groups / seminars/ workshops/.