Contact Information

Client name:______________________________ DOB:__________ School:________ GR:______

Name of person completing form:________________________ Relationship to client:______________

Address:______________________________ City:______________ State:_____ Zip:_________

Home number: ____________ Cell number:________________ Email:____________________

Other parent/guardian name (if applicable):________________________ Custody: joint standard other

Second Address:_________________________ City: _____________ State:_____ Zip: _______

Best phone:______________ Email:____________________

Emergency Contact Name/Relationship to Client:____

Emergency Contact Phone Number:______________________

How did you hear about Houston Therapy for Girls?______________________________________

Newsletter Updates (once a month) : **YES** **NO**

Payment Information

Payment for all sessions is due at the time of service. For ease of billing, we request your credit card information to be kept on file. Your information is confidential and will only be used for payment for you or your child's sessions.

I, _________________________, authorize HTFG to charge my credit card for professional services rendered to me and/or my child/adolescent and to keep my credit card number on file for future use. I verify that my credit card information, provided below, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

Name on CC:____________________CC #:____________________Exp:______CVV:_____

Billing zip code (if different than above):____________ Signature:__________________________

MEDICAL INFORMATION (Please check all that apply)

Sleeping patterns: □ normal/no concern □ not enough sleep □ too much sleep

Eating patterns: □ normal/no concern □ not enough □ too much

Current Primary Care Physician: __________________ Psychiatrist (if any):________________

Medications:____

MENTAL STATUS (Please circle all that apply)

sad angry anxious hyper unable to focus worried extreme ups/downs distant

tearful helpless hopeless negative attitude power struggles avoidant irritable

Welcome to Houston Therapy for Girls PLLC ("HTFG"). We appreciate your confidence in our ability to facilitate growth your child/adolescent.

The following is an agreement entered into between _____________________________(clinician name) of Houston Therapy for Girls and _____________________________(as representative of client). By signing below, you hereby give full consent for your child/adolescent _____________________________(name of client) to participate in treatment.

You further certify you have the legal authority to authorize and consent to this treatment as parent(s), managing conservator, or guardian(s) of this child/adolescent.

In case of a divorced/divorcing family, please indicate whether the child/adolescent is subject to a court order (e.g., divorce decree):
______Child/adolescent **IS** subject to a court order
______Child/adolescent **IS NOT** subject to a court order

If the child/adolescent is subject to a court order, I will need to see a **full, true, and correct** copy of that court order before meeting and working with the child/adolescent.

The modalities of outpatient psychotherapy utilized in this office are widely accepted forms of psychological treatment. However, as with all forms of clinical treatment, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of outpatient therapy and to discuss the general policies and procedures of our office.

OVERVIEW OF CLINICAL SERVICES

We use a variety of outpatient treatment modalities, including individual, family, and group psychotherapy. Our treatment approach is based upon each client's specific clinical needs as identified during the initial assessment session(s). The client's therapy options are then discussed and a plan for treatment is determined. A client's needs sometimes change over the course of their outpatient therapy which may necessitate a reevaluation of their treatment plan. When this occurs, treatment options are once again discussed and determined by the client and therapist. If at any time the client and/or therapist believe the client's clinical issues require alternative or additional resources, every effort will be made to assist the client in locating those resources.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment.

A client may end treatment with the therapist at any time, and the only tasks the client will be responsible for are notifying the therapist and paying for the services the client has already received. I understand that if I stop my treatment with the therapist, she will ask that I speak with her about my

reasons for doing so. I understand that she may suggest continued treatment with a different provider if she assesses that continued treatment is recommended.

Your therapist may terminate treatment if your therapist determines that the psychotherapy is not being effectively used or if you are in default on payment.

If therapy is terminated for any reason or you request another therapist, your therapist will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, your therapist must consider the professional relationship discontinued.

BENEFITS AND RISKS OF TREATMENT

The benefits of outpatient psychotherapy may include improved functioning in relationships, improved communication skills, and a reduction in the symptoms that led you to seek therapy in the first place.

The risks or potential side effects of participating in psychotherapy may, at times, include increased levels of stress and anxiety, escalation of undesired behaviors, relationship disruption, and emotional reactivity.

APPOINTMENTS AND CANCELLATIONS

HTFG attempts to schedule appointments at the frequency that is best for you and your child/adolescent's situation. If a scheduled appointment must be changed, please contact the office at least 24-hours in advance, weekends included, at **281.671.4259**. Because your appointment time has been reserved for you and/or your child, **HTFG charges the full fee for appointments not cancelled at least 24-hours in advance, illness or emergencies excluded.**

APPOINTMENT REMINDERS

HTFG will send out appointment reminders via email one day prior to all sessions. **Please notify your therapist if you wish to opt out of receiving appointment reminders.**

EMERGENCIES

Due to the nature of the work at HTFG, clients might find themselves in an emergency situation where they need immediate assistance. The first step is to call your primary physician or psychiatrist. After this, please notify HTFG via telephone, and we will return your call **as soon as possible**. Please note that text messages and email are not designed for emergency contact–they occasionally get delayed and are on rare occasion lost. If you are in imminent danger, please call 911 and ask for the mental health deputy or go to your nearest emergency room.

In the event of an emergency with your therapist, you will be notified as quickly as possible of the emergency. In the event of a long-term disability or the death of your therapist, arrangements have been made for another psychotherapist to assume control of your therapist's records; to make

appropriate referrals to other providers, if necessary; and to take all reasonable steps to manage the practice for the benefit of our clients. By your signature below, you authorize your therapist's designee to contact you directly and use and disclose your confidential mental health information and records for the stated purposes.

FEES AND PAYMENT

Payment is due in full at the time of service.

- Individual or family session:
  - 50 minutes: $200
  - 80 minutes: $320
  - 30 minutes: $120
- Group therapy (90 minutes) is $85 per session plus a one-time registration/supplies fee of $25 (process groups) or $50 (art journaling groups). For a ten week Group Therapy Cohort, we charge a nonrefundable fee of $875 for process cohorts (includes a $25 registration/supply fee) and $900 for art journaling cohorts (includes a $50 registration/supply fee). The registration/supply fee plus 50% of the cohort fee is due the first week the cohort meets and the remaining cohort fee is due by the fifth week. If the cohort is scheduled to meet for less than ten sessions, we will adjust the cohort fee and due date accordingly. In the event your daughter doesn't attend a session **for any reason**, a credit will not be issued.
- Telephone calls in excess of 15 minutes in length but 30 minutes or less will be billed at $120. Phone calls in excess of 30 minutes will be billed at the hourly (50 minute) rate.

HTFG requires a credit card on file to insure payment at time of service; however, you may also choose to pay with check or cash at time of service. For credit card payment, we accept Visa, MasterCard, American Express, Discover, Diner's Club, and JCB, including HSA and FSA cards with a Visa, Discover, MasterCard, or American Express logo on the card. Please make checks payable to Houston Therapy for Girls. Delinquent accounts will be referred for collection.

INSURANCE

HTFG is out of network for insurance plans, and we do not file with insurance. Upon request, we will provide you with a superbill that includes the information necessary for you to file with your insurance company for out-of-network reimbursement. The amount you may be reimbursed depends on your policy, and we recommend that you call your insurance company to find out exactly what they are willing to cover.

Although it is not usually required for out-of-network benefits, occasionally an insurance plan may require a prior authorization for services. **You are responsible for obtaining any prior authorizations or pre-certifications that are required by your plan.**

GROUP THERAPY

A Group Therapy Cohort consists of up to 8 girls who usually meet for eight to ten weekly 90-minute sessions. In order to ensure that the cohort successfully meets its objectives, each girl should attend and participate in all scheduled weekly sessions, and cohorts are closed to new members

after the second session. Therefore, for group therapy, payment is required for all eight to ten weekly sessions, whether or not your child/adolescent is present.

CASE EVALUATION

In order to ensure the best treatment possible for each client, HTFG does consult with other professional therapists regarding cases. This is common practice among therapists and is also referred to as "case conference" or "peer review." Information about you may be shared in this context without using your or your child's name.

CLIENT LITIGATION

HTFG will not voluntarily participate in any litigation or custody dispute in which the client is involved. This includes communication with the client's attorney, as well as documentation such as letters, reports, and affidavits. Testimony will not be provided by HTFG.

Should HTFG be ordered by a court of law (judge) to appear as a witness in an action involving the client, the client agrees to reimburse HTFG for any time spent out of the office, for preparation, and for travel at the rate of $500.00 per hour.

EMAIL AND TEXT MESSAGES

As stated in our Social Media policy, HTFG prefers to use email and text message only to arrange or modify appointments. We recognize that email and text message can facilitate communication; however, we cannot guarantee the privacy or security of any messages that are sent over email and text.

While we do everything we can to protect your confidentiality, sending electronic messages poses a potential risk for insecure communication. Also, you should know that any emails and text messages that HTFG receives from you, and any responses HTFG sends to you, by law become a part of your mental health record.

______I am well aware of and agree to the terms listed on this form and hereby consent to and authorize the use of email and text message as a form of communication between HTFG and myself.
______I do **NOT** consent to the use of email and text message as a form of communication between HTFG and myself.

CONFIDENTIALITY

What you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statues, court order, or as part of the professional practice of HTFG. For further information, please see our Notice of Privacy Practices. Details over confidentiality will be discussed in depth in the initial assessment session.

LIMITATIONS TO CONFIDENTIALITY

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission. However, there are exceptions. These include:

- Suspected child abuse or dependent adult or elder abuse, for which the therapist is required by law to report this to the appropriate authorities immediately.
- If a client is threatening serious bodily harm to another person, the therapist is required by law to report this to the appropriate authorities immediately.
- If a client intends to harm herself, the therapist will make every effort to enlist their cooperation in insuring their safety. If she does not cooperate, the therapist will take further measures without their permission that are provided to the therapist by law in order to ensure their safety.
- If a court of law issues a legitimate subpoena for information stated on the subpoena.

CONFIDENTIALITY REGARDING MINORS

The issue of confidentiality is critical in treating children/adolescents. When children/adolescents are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children/adolescents seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality; their parents have the right to view their children/adolescent's treatment records. However, unless children/adolescents feel they have some privacy in speaking with the therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children/adolescents feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child/adolescent in therapy. For example, all can agree that unless the child/adolescent has been abused or is a clear danger to self or others, the therapist will normally disclose **only** the following:

- whether sessions are attended
- whether the child/adolescent is generally participating or not
- whether progress is generally being made or not

If you believe there are significant health or safety issues that I need to know about, please contact me, and we will discuss how to proceed with addressing these issues.

COMPLAINTS

You have a right to have your complaints against your therapist heard and resolved in a timely manner. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with my licensing board: The Texas Behavioral Health Executive Council, at 512.305.7700. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U.S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

By signing this document I acknowledge informed consent in my decision to seek outpatient psychotherapy for my child/adolescent with this therapist and I have had an opportunity to ask questions. I also acknowledge that my signature below means that I understand and agree with all of the points above. I further certify that I have the legal authority to authorize and consent to this treatment as parent(s), managing conservator, or guardian(s) of this child/adolescent.

____ ______________________

Signature of Parent/Guardian Date

____ ______________________

Signature of Parent/Guardian Date

I, the therapist, have discussed the issues above with the child/adolescent's parent/guardian. My observations of this person's behavior and responses give me no reason, in my professional judgement, to believe that this person is not fully competent to give informed and willing consent to the child/adolescent's treatment.

____ ______________________

Signature of Clinician and Credentials Date

_______Copy accepted by client
_______Copy kept by therapist

This is a strictly confidential client mental health record. Redisclosure and/or transfer is expressly prohibited by law.