1612 Williams Dr. Georgetown, TX 78628

CLIENT INFORMATION

Client Last Name: _____ **DOB:** _____

Client First Name: _____ **Nickname?** _____

If patient is a minor:

Father's Name: _____

*Phone Number:*_____*home/work/cell*

*Phone Number:*_____*home/work/cell*

Email: _____

Mother's Name: _____

*Phone Number:*_____*home/work/cell*

*Phone Number:*_____*home/work/cell*

Email: _____

What is client's current living arrangement? Both parents? 50/50 visitation? Etc

_____

. _____

Client Address: _____

City, State, and ZIP: _____

Responsible Party (who pays the bill?): _____

Responsible Party Address: _____

City, State, and ZIP: _____

Responsible Party Home Phone: _____ **Cell Phone:** _____

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Client's Email Address (or parent's if minor): _____

Appointment reminders?

____ Email Address: _____

____ Text Message: Cell Number _____

____ None

Primary Insurance: _____ **Insurance Phone Number:** _____

Insurance ID Number: _____ **Group Number: (or NONE)** _____

Client's relationship to insured: ___self ___spouse ___child _____other

Insured's Name (Last, First, MI): _____

Insured's Street Address: _____

Insured's City and ZIP: _____

Insured's Date of Birth: _____

If applicable:

Secondary Insurance: _____ **Insurance Phone Number:** _____

Insurance ID Number: _____ **Group Number: (or NONE)** _____

Client's relationship to secondary insured: ___spouse ___child ___other

Insured's Name (Last, First, MI): _____

Insured's Street Address: _____

Insured's City and ZIP: _____

Insured's Date of Birth: _____

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I hereby authorize TURNING POINT PSYCHOLOGICAL AND COUNSELING SERVICES, PLLC to furnish information to my insurance carriers concerning my illness and treatment. I hereby authorize TURNING POINT PSYCHOLOGICAL AND COUNSELING SERVICES, PLLC to provide treatment for me and/or my dependents.

I authorize payment of medical benefits to TURNING POINT PSYCHOLOGICAL AND COUNSELING SERVICES, PLLC.

SIGNATURE:_____DATE:_____

FEES: Fees for services are as follows:

	Dr. Eichler	*PhD / PsyD*	*LPC*
Initial Evaluation (typically 60 min)	$225	$200	$170
Individual Psychotherapy (55-60 min)	$190	$175	$155
Marital/Family Psychotherapy (45-55 min)	$190	$175	$165
Marital/Family Psychotherapy(80 min)	$225	$200	$170
Group Counseling (55-60 min)	$75	$75	$60
Group Counseling (80-90 min)	$100	$100	$75
Court Testimony—Full / Half day* not including travel over 50 miles	$3000 / $1500	$1500 / $750	$1250 / $625
Written reports/letters	---- $100/page ----		
Records request	---- $35 first 20 pages, $1 per additional page		
Missed appointment/late cancellation	---- $100.00 ----		
Phone, email, or additional contact**	-- $35/15 minutes (billed by quarter hour) --		

** Court testimony by postdoctoral resident therapists will include an additional, mandatory $250 fee for required supervision by Dr. Eichler. No refunds for reserving the day unless the cancellation is 72 hours in advance.*

*** Contact made on behalf of the client, other than those related to scheduling, either at the client's request or to satisfy transmission of information necessary for the treatment, including but not limited to phone calls, emails, or other additional contacts, will be billed at the above rate. This includes talking with attorneys.*

COURT: Payment of the court fee is due a week prior the court appearance in order to clear schedules and reserve the date.

_____ CLIENT INITIALS _____WITNESS INITIALS

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EMAILS: As Turning Point works with court cases, a $200 retainer is collected to review relevant documentation, phone calls, written correspondence (including email), and any other form of communication that needs to occur (outside of joint or individual sessions) in order to provide services to you. No clinician will engage in therapy via email. Clinicians will read emails for informational purposes, and will exchange basic information (e.g. appointment times). If there is an issue that needs to be discussed, it is best to set up an appointment and process the issue in person. Emails to attorneys will be billed at the rate for additional contact listed above.

CANCELLATION NOTICE: There is no charge for cancellation of appointments if notice is given more than 24 hours in advance. A fee of $100.00 will be charged if you give less than 24 hours' notice of cancellation or do not appear for your appointment. *These fees are not covered by any insurance company*

If you arrive late for your scheduled session, that session will be shortened by the amount of time that you are late. You are required to provide credit or debit card information for the purpose of charging fees for missed appointments or cancellations with less than 24--- hour notice. Frequent cancellations indicate a need to address the issue during the therapy session; therefore, you should be prepared to do so. Returned checks are subject to an additional fee of $35. If your check is returned, you will be required to make any future payments by cash or money order.

CONFIDENTIALITY: Individuals seeking mental health services should be clearly informed about their confidentiality rights. Generally, information that you discuss with your therapist is strictly confidential and will not be discussed with anyone without your expressed written consent. This means that anything that is told in a therapy session will not be reported to anyone, even other family members. However, there are some exceptions. Confidentiality may be broken under any of the following circumstances:

1. If a court of law orders your records.
2. If you threaten to harm yourself.
3. If you threaten to harm someone else.
4. In cases of abuse of children, the elderly, or those with a disability.
5. If you are using a mental health insurance policy, to pay for your visits, we may be required to provide certain diagnostic and basic treatment information in order to obtain payment for our services.

_____ CLIENT INITIALS _____WITNESS INITIALS

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Parents / Guardians: If you are seeking services for a child or adolescent, you may be required to participate in family sessions. You should also know that it is within your rights, as parents or legal guardians of minor children (under the age of 18), to request information concerning your child's progress and treatment. However, it is often harmful to the therapeutic process if the clinicians at Turning Point are not able to assure your child that our work will remain confidential. Turning Point believes that therapy is only beneficial if it provides a safe environment in which clients can openly explore their own value system and examine their choices and behaviors in a non---judgmental context. To this end, clinicians will not be sharing with you everything that your child talks about in therapy. As parents / guardians, we ask that you agree not to ask specific questions concerning the detail or content of information disclosed during individual sessions with your child. In turn, we agree to work collaboratively with him/her in an effort to provide you with general updates when requested and disclose information to you in preservation of the therapeutic relationship. Trust that we will let you know if we do not think your child is benefiting from therapy.

_____ CLIENT INITIALS _____WITNESS INITIALS

Clinicians may engage in periodic staffing or consultation with other counseling professionals about client related issues as a means of providing better services to clients. However, information revealing client identity will remain in confidence according to the limits of confidentiality outlined above. If by chance, our paths cross outside of the office (i.e., we see you at a restaurant, store, etc.), please understand that we will respect your confidentiality and refrain from acknowledging you. If you are comfortable and you choose to acknowledge us, know that we will follow your lead with regard to communication, and we will not be offended at all if you choose not to acknowledge us in public.

_____ CLIENT INITIALS _____WITNESS INITIALS

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with anyone here at Turning Point.

Signature: _____ Date: _____

Witness: _____ Date: _____

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AUTHORIZATION FOR CREDIT CARD CHARGES

TURNING POINT PSYCHOLOGICAL AND COUNSELING SERVICES, PLLC requires clients to provide a credit card on file to guarantee payment for services. This information is maintained in a secure location alongside the client's therapeutic information. If you have questions about the security of your information, you should discuss this with your therapist prior to signing this form. By signing this form, you agree to the following:

- ☐ *I give permission for my credit card to be charged for any outstanding balances beyond two weeks.*
- ☐ *I give permission for my credit card to be charged for session fees for which insurance has denied payment for any reason. Appeals for insurance coverage are then my responsibility, and I should handle these directly with my insurance company.*
- ☐ *I understand that insurance benefits will be confirmed as a courtesy prior to initiating services, but this does not guarantee insurance coverage for any session. I understand that it is my responsibility to talk with my insurance company prior to initiating any services to confirm the benefits for myself.*
- ☐ *I give permission for my credit card to be charged for any customary fees as outlined on the professional disclosure statement I signed upon initiating therapy. These fees include late cancel fees, no show fees, and court testimony fees.*
- ☐ *I agree that I will not pursue a chargeback for legitimate credit card charges for actual services provided by a therapist affiliated with Turning Point Psychological and Counseling Services, PLLC.*
- ☐ *I agree to provide Turning Point Psychological and Counseling Services with updated credit card information when a new card is issued or an account is closed for the duration of treatment.*
- ☐ *I am freely giving permission for this credit card information to be held on file as guarantee of payment for any actual provided services.*

CREDIT CARD TYPE:_____Visa _____Mastercard

Account Number: _____ **Security Code:** _____

Expiration: _____ **Address:** _____

Email address (for credit card receipt): _____

Signature: _____

If you would like all session fees and copays to be charged on this card regularly, please indicate that by initialing here:_____. By doing so, you are acknowledging that recurrent fees for sessions may be charged as they are accrued

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AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS OR INFORMATION

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this authorization by writing the word "REVOKE" along with my signature and the date at any time after it is signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all members, aged 18 or over, participating in services with Turning Point; or information released must be restricted only to information regarding the person(s) who signs the release on behalf of him/herself or a minor child of whom they have legal right to consent for treatment. If not previously revoked, this authorization will automatically expire one year following completion of the services with this provider.

I also understand that copies of records will be subject to a fee of $35 retrieval fee plus $1/ page, except where prohibited by law. I also understand that I will be responsible for any additional fees required to process my request, including, but not limited to: notary, certified and/or overnight mailing, faxing, or photocopying.

I authorize Turning Point Psychological and Counseling Services, PLLC to:

( ) Disclose (share) information with: *AND/OR* ( ) to obtain (receive) information from:

_____

Name Relationship to Client

_____

Email Phone

Information to be disclosed/exchanged includes:

( ) Any relevant information in my records.

( ) Only the following information **(<u>Must initial each item</u>):**

___ Information regarding attendance at scheduled appointments
___ Clinical records
___ Oral consultation only regarding progress
___ Other: _____

_____

Client Name (print) Parent/ Guardian Name (print), *if client is under 18*

_____

Signature Date

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Notice of Privacy Practices

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

1. **PURPOSE:**

   Turning Point Psychological and Counseling Services follow the privacy practices described in this Notice. Turning Point Psychological and Counseling Services keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional and administrative members involved in your treatment, or involved in the health care operations of the agency, have access to your records.

2. **WHAT ARE TREATMENT and HEALTH CARE OPERATIONS?**

   Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing both an individual counselor and a family therapist, Turning Point Psychological and Counseling Services may share information in the process of coordinating your care with a proper release. Treatment records may be reviewed as part an on-going process directed toward assuring the quality of operations. Staff members designated by the Quality Improvement Committee may access clinical records periodically to verify that standards are met.

3. **HOW WILL TURNING POINT PSYCHOLOGICAL AND COUNSELING SERVICES USE MY PROTECTED HEALTH INFORMATION (PHI)?**

   Your personal mental health record will be retained by Turning Point Psychological and Counseling Services for at least seven years after your last clinical contact with the agency. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy.

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Until the records are destroyed they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

- Appointment reminders;
- Notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law);
- Mental health oversight activities, e.g., audits, inspections or investigations of administration and management;
- Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record.);
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred in the Counseling Center; when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out treatment and health care operations functions through medical transcription services;
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority;
- National security and intelligence activities;
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- To support the operations and functioning of the practice. All business associates (e.g., electronic health record vendor) connected to the practice are obligated to protect the privacy and security of your PHI and may not use or disclose your PHI other than as specified in our agreements with them.

4. **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES.** Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing for Turning Point Psychological and Counseling Services to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

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5. **YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI).** You have the following rights regarding your health information, provided that you make a written request to invoke the right to Turning Point Psychological and Counseling Services:

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied.
- Right to an electronic copy of mental health records. If your PHI is maintained in an electronic format (known as an electronic health record), you have the right to request that an electronic copy of your record be given to you or another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in that form or format. If it is not readily producible in the form or format you request, your record will be provided in either our standard electronic format, or, if you do not want this format, as a readable hard copy. We may charge a fee for transmitting the electronic health record. Right to request a clarification of record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. Turning Point Psychological and Counseling Services is not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations. Right to receive notice of a breach. You have the right to be notified upon a breach of any of your unsecured PHI.
- Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

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6. REQUIREMENTS REGARDING THIS NOTICE.

Turning Point Psychological and Counseling Services is required to provide you with this Notice that governs our privacy practices. The Counseling and Mental Health Center may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you come in to Turning Point Psychological and Counseling Services for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you have any further questions regarding HIPAA, you may visit www.hhs.gov/ocr/hipaa or call directly at 1-800-627-7748. Turning Point Psychological and Counseling Services will not retaliate against you for filing a complaint.

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PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment but in refusing we will not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Turning Point Psychological and Counseling Services, PLLC. A copy of this signed and dated Acknowledgment shall be as effective as the original.

_____ _____

Client Name Client Signature

_____ _____

Parent/ Guardian/ Legal Representative Description of Authority

_____

Date

Comments regarding Acknowledgments or Consents: _____

_____

OFFICE USE ONLY:
Turning Point Psychological and Counseling Services attempted to obtain the patient's (or representative) signature on this Acknowledgment but did not because:

__It was emergency treatment __The patient refused to sign __Other_____

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Social Media Policy

Turning Point Psychological and Counseling Services may have various social media accounts (ie: Facebook, Twitter, LinkedIn and Google+), allowing us to share practice information, news and event updates with other social media users. In addition, clinicans with Turning Point may also have social media accounts for personal and private use. This document outlines our practice's policy related to use of Social Media. Please read it to understand how we conduct ourselves on the social sites as mental health professionals and how you can expect us to respond to various interactions that may occur between clients and clinicians on the Internet.

This policy is not meant to keep you from sharing that you are in therapy at Turning Point or with a particular clinican wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client. You are encouraged to take your own privacy as seriously as we take our commitment of confidentiality to you.

Friending

Clinicians will not accept "friend" requests from current or former clients on their personal social networking sites (Facebook, Twitter, LinkedIn, etc.). Likewise, Turning Point will not accept requests on any social media accounts it may have. Adding clients as "friends" on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your therapist.

Liking/Following

You are welcome to "like" or "follow" any Turning Point social media feeds and read or share articles we may post; however, because social media sites are public spaces, anyone who can see our social media pages can see your post or comment. In addition, when you post, comment, or "like" a page, it will be published on your page as well. Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow our practice.

In order to maintain ethical boundaries, therapists are not permitted to follow you back. We believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on the therapeutic relationship. If there are things from your online life that you wish to share with your therapist, please bring them into the sessions where those things can be viewed and explored with your counselor, during the therapy session.

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As Turning Point and your therapist will treat your privacy and confidentiality with the highest level of importance and the utmost respect, please recognize that your therapist also has a private life outside of the therapeutic office. We ask that you also respect your therapist, their family, and their right to privacy.

Texting/ Messaging

Please do not use SMS (mobile phone text messaging), wall posting, @ replies, messaging on Social Networking sites in order to contact your therapist. Engaging with your therapist in this way could compromise your confidentiality, as confidentiality cannot be guaranteed, and the therapist may not even receive your message. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines

It is NOT a regular part of our practice to search for clients on Google, Facebook, or other social media or search engines. Due to the fact that therapists are mandated reporters, extremely rare exceptions may be made during times of crisis. If a therapist has reason to suspect you are in danger and you have not been in touch with your therapist via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if your therapist resorts to such means, the information will be fully documented and discussed with you during your next session.

Business Review Sites

You may find Turning Point on sites such as Yelp, Bing, Psychology Today, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find Turning Point on any of these sites, please know that this listing is not a request for a testimonial, rating, or endorsement from you as a client. The American Psychological Association and American Counseling Association's Code of Ethics prohibit clinicians from requesting testimonials for marketing purposes.

If you are using these sites to communicate your feelings about your therapeutic experience with your therapist, the communication may not be seen by your therapist. You have a right to express yourself on any site you wish; however, due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. Our hope is that you will bring your feelings and reactions concerning your treatment directly into the therapy process. This can be an important part of treatment, even if you decide to go elsewhere.

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If you do choose to write something on a business review site, please keep in mind that you may be sharing personally revealing information in a public forum. If you feel your therapist has done something harmful or unethical, and you do not feel comfortable discussing it with your therapist, you should contact the Texas State Board which oversees your clinician's particular mental health license, and they will review the situation you have identified.

Licensed Professional Counselor

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

Location-Based Services (LBS)

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in" from our office or if you have a passive LBS app enabled on your phone.

Conclusion

Thank you for taking the time to review our Social Media Policy. If you have any questions about anything within this document, you are encouraged to bring them up with your therapist or contact our administrative office. As new technology develops and the Internet changes, there may be times when this policy needs to be updated. Any updates or changes will be posted in our office and reviewed with you.

Signature: _____ Date: _____

Witness: _____ Date: _____