# Client Information and Consent

***Please closely read this document and complete, initial, and sign in all indicated areas.***

## PATIENT RESPONSIBILITY

We consider our patients to be active members in the therapeutic treatment process. As an active member in your treatment, we ask you to closely read this document, ensure you understand the content, and ask any questions you may have. If the patient is a minor and not able to comprehend the content in this document, we ask the legal guardian to read it and ask questions. In this scenario, only the guardian is expected to sign the document. If the patient is a minor and able to comprehend the content in this document as written, it is expected that both the patient and the guardian will read it, ask any questions they have, and initial/sign the document.

## PROVIDERS

The providers listed below are independently licensed psychologists engaged in private practice providing mental health care services to clients directly and as independent contractors/providers for various managed care entities. In addition, as shareholder and employee of their companies, the undersigned mental health providers provide all mental health services through the below corresponding company titles.

| | | |
|---|---|---|
| Debra Archuleta, Ph.D. | | M&L Behavioral Health Consultants, PLLC |
| Hunter Hansen, Psy.D., LMFT | | Dr. Hunter Hansen, PLLC |
| Christopher Howells, Psy.D. | | No Limits Psychological Services, PLLC |
| Teresa Hughes, Ph.D. | | TMH Total Mental Health, PLLC |
| Kevin M. Pernicano, PhD, ABPP | | Pernicano Professional Psychology, PLLC |
| Trudi Zaplac, J.D., Ph.D. | | Trudi Zaplac, Ph.D., PLLC |

## APPOINTMENTS

### Scheduling Appointments

Appointments are made by calling (210) 202-0100 Monday through Friday between the hours of 8:00 a.m. and 4:00 p.m. We will respond to e-mail requests for appointments via phone within two business days.

### Number of Appointments

The number of sessions needed to help you achieve your therapy goals depends on many factors and should be discussed with your provider.

### Length of Visits
Most therapy sessions are 45 minutes but may be shorter or longer for initial visits or psychological testing. Medication management sessions will vary in length from 15 to 120 minutes.

## MENTAL HEALTH TREATMENT

### Mental Health Services
We appreciate that it is not always easy or comfortable to seek help from a mental health professional. We hope your treatment experience will enable you to better understand your situation and feelings to allow you to meet the goals that you set for your life. The mental health provider, using knowledge of human development and behavior, will make observations about situations as well as suggestions for new strategies to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches for change to occur. You may bring other family members to a treatment session if you feel it would be helpful or if this is recommended by your mental health provider. The success of your treatment depends on the quality of the efforts of both you and your provider, consistent attendance of treatment sessions, and your commitment to change. Ultimately, you are responsible for the lifestyle choices/changes that may result from treatment.

### Risks of Therapy
Therapy is the Greek word for change. One risk of therapy is that you may learn things about yourself that you do not like. You may feel emotionally uncomfortable at times since growth often occurs when one experiences and confronts issues that induce sadness, sorrow, anxiety, or pain. After making changes in your thinking and/or behaviors, your friends and family may respond differently to you and it is impossible to predict their response. One risk of marital therapy is the possibility of deciding to divorce after reaching greater insight.

### Relationship
An essential element of mental health treatment is the professional and therapeutic relationship with your mental health provider. It is different from other relationships in your life, such as with your family and friends, in that it allows an objective view of your concerns. In order to preserve this relationship, it is imperative that the mental health provider not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The mental health provider cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the mental health provider.

### After-Hours Emergencies
Emergencies are urgent issues requiring immediate action. If you experience a mental health emergency after hours, please go to the closest Psychiatric Hospital or Emergency Department. These facilities can assist you in getting an evaluation by a provider trained to evaluate the need for urgent care, including hospitalization. If hospitalization is necessary, please have hospital staff or a family member contact your mental health provider on the next business day. You may follow-up with your mental health provider after you are discharged from the hospital. Your mental health provider is not affiliated with any Emergency Department or hospital nor does your mental health provider have admitting privileges at any hospital. Your mental health provider does not provide services at any inpatient facility and cannot provide services to you while you are hospitalized.

________________________________ Patient or Guardian Initials

## 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 the elderly or disabled
- 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 mental health provider has a duty to disclose, or where, in the mental health provider's judgment, it is necessary to warn or disclose
- fee disputes between the mental health provider and the client
- a negligence suit brought by the client against the mental health provider
- the filing of a complaint with the licensing board.

If you have any questions regarding confidentiality, you should bring them to the attention of the mental health provider when you and the mental health provider discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned mental health provider to share confidential information with all persons mandated by law, with the agency that referred you, and with the managed care company and/or insurance carrier responsible for providing payment for your mental health services. You are also releasing and holding harmless the undersigned mental health provider from any departure from your right of confidentiality that may result.

### Contact

I consent for the undersigned mental health provider and other clinic staff to communicate with me by mail and/or by phone at the address(es) and phone number(s) listed in the Patient Intake Questionnaire, and I will IMMEDIATELY advise the mental health provider in the event of any change.

### Mental Health Provider's Incapacity or Death

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

________________________________ Patient or Guardian Initials

## Duty to Warn **(Please provide a name and phone number. Initial at the end of the line).**

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

Name of emergency contact: ___________________________________________________________
Phone number for emergency contact: ___________________________________________________

_______ Initial (indicating consent to contact the above individual in a duty to warn situation)

## Consent to Treatment

I voluntarily agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned mental health provider to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned mental health provider at any time.

My initials on the below items and signature at the bottom of this document indicate that:

I understand that, ultimately, I am financially responsible for ensuring that my account is paid in full regardless of whether or not I have primary and/or secondary insurance.
I have both read and understand the information in this Client Information and Consent form.
I have been given ample opportunity to ask questions and seek clarification of anything unclear to me.
I have been offered a copy of and/or received a copy of the Client Information and Consent Form.
I have been offered a copy of and/or received a copy of the current HIPAA Compliance Laws and Regulations and that I understand my rights under HIPAA.

_____________________________ _______________________________ _______________
Client Name Signature Date

_____________________________ _______________________________ _______________
Guardian Name (if client is a minor) Signature Date

as witnessed by:

_____________________________ _______________________________ _______________
Provider or Staff Name Signature Date

_______________________________ Patient or Guardian Initials

# Client Information and Consent

***The following notice and consent documents meet the requirements as specified by the Secretary of HHS under 45 CFR 149.410 and 149.420.*** **OMB Control Number [0938-0000] Expiration Date [02/01/2023]**

## FEES, GOOD FAITH ESTIMATE, CANCELLATION/NO SHOW POLICY, and PAYMENTS

The clinic will look to you for full payment of your account and you will be responsible for payment of all unpaid charges.

Under Section 2799B-6 of the Public Health Service Act, health care providers need to give patients who *do not have* insurance or who *are not using* insurance an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

_______________________________ Patient or Guardian Initials

## STANDARD FEES FOR SERVICES

**PSYCHOLOGY: Child and Adult Therapy Services**

Address for all services is 8628 Tesoro Dr., Suite 490, San Antonio, TX 78217 OR via telehealth.

| Service | Diagnosis Code | Service Code | Quantity | Expected Cost |
|---|---|---|---|---|
| Intake (first appointment) | TBD | 90791 | 1 | $275[1] |
| Follow-up sessions (53-60 min) | TBD | 90837 | Avg 20 | $200/session[1] |
| Psychological testing | TBD | TBD | TBD | TBD[2] |
| Obtaining a copy of mental health records | TBD | N/A | 1 | $18[3] |
| **Missed appointments/ late cancellation charge** | TBD | N/A | 1-3[4] | $100[3,4] per missed appt |

[1] If insurance deductible is not met OR insurance is not used. Depending on your insurance plan, this could be a negotiated lower rate.
[2] Varies (written estimate to be provided at least 24 hours prior to beginning testing)
[3] Insurance companies do not cover these fees
[4] After 3 "no show" appointments or late cancellations (canceling within 24 hours of the appointment without valid cause), care may be terminated by your provider.

**NOTE**: In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the mental health provider's hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time of or prior to the time the services are rendered by the mental health provider.

## Good Faith Estimate for Patients WITH Insurance

**Deductibles and copayments.** If you have insurance, your mental health provider is in-network, and you are using insurance to pay for your sessions, you are responsible for payment of all charges including co-payments, the full cost of sessions until your insurance deductible is met, and/or the full cost of the session if your insurance carrier declines payment. Payments are due at the time services are rendered. Different co-payments are required by various group coverage plans. Your co-payment is based on the Mental Health policy selected by your employer or purchased by you. In addition, the co-payment may be different for the first visit than for subsequent visits. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company. ***We recommend that you contact your insurance company to learn your portion of your deductible, copayment, and/or coinsurance for mental health services.***

**Secondary Insurance.** If you have a secondary insurance, you must provide this information at the beginning of mental health services or at the time you purchase this insurance. We will make two attempts to file claims with primary and secondary insurance. If the secondary insurer does not pay the balance, you are responsible for the balance and you can contact your insurance companies to determine the appropriate procedures for requesting reimbursement from them directly.

**If you change insurance companies, decide to use insurance after not using insurance, or decide to not use insurance after using it, you must inform the staff immediately of this change.**

_______ **(Initial)** By initialing this box, you understand that you are ultimately responsible for paying all fees associated with your mental health care. You are responsible for understanding your insurance coverage and the fees to be paid by you.

## Good Faith Estimate for Patients WITHOUT Insurance or NOT using Insurance

If you do not have insurance or are choosing to not use insurance, you are responsible for paying for your sessions (please see the chart at the beginning of this section for standard rates).

______ **(Initial)** Initialing this box indicates that you understanding that you are responsible for paying for your session in full at the time of service.

## Cancellations, No Shows, and Late Cancellations

**Cancellations.** If you want or need to cancel an appointment, you must do so more than 24 hours before the start of the appointment. If your appointment is on a Monday morning or the first day after a holiday, you may leave a message on the office voicemail.

**No Shows and Late Cancellations.** Failing to show up for or cancel an appointment you do not attend is called a "No Show." Canceling an appointment with less than 24 hours' notice is called a "Late Cancellation." If you fail to show up to an appointment or cancel with less than 24 hours' notice, we cannot use this time for another client and you will be billed for the missed appointment. Your credit card will be charged or a bill will be mailed to you if you do not show up for a scheduled appointment or cancel with less than 24 hours' notice.

______(Initial) A fee of **$100** is charged for missed therapy appointments or cancellations **with less than a 24-hour notice** unless it is due to illness or emergency. **Your credit card will be charged, or a bill will be mailed for a No Show or Late Cancellation.**

## Payments

Payments may be made in the form of credit card, debit card, check, or cash. We do not maintain cash in the clinic and cannot make change. Checks should be made out to the provider directly. Invoices will be mailed out to the address on file for all outstanding fees.

| ______________________ | ______________________ | __________ |
|---|---|---|
| Client Name | Signature | Date |

| ______________________ | ______________________ | __________ |
|---|---|---|
| Guardian Name (if client is a minor) | Signature | Date |

as witnessed by:

| ______________________ | ______________________ | __________ |
|---|---|---|
| Provider or Staff Name | Signature | Date |