Intake

Patient Information

Name of Patient: _____ Home Phone:_____
Address: _____Work Phone: _____
_____ Cell Phone: _____
Date of Birth: _____ Age: ____ Sex: ____ SS#: _____
Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed
May we leave messages on your voicemail? _____ May we text you? _____
Employer: _____
Employer's Address: _____

Reason for Appointment: _____
_____

Referral

Who referred you to my office?
Name: _____ Address: _____

Family Information

Name of Spouse or Parent: _____ Home Phone:_____
Address: _____Work Phone: _____
_____ Cell Phone: _____
Date of Birth: _____ Age: ____ Sex: ____ SS#: _____
Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed
Employer: _____
Employer's Address: _____

Insured Information

NOTE SLT Therapy, PLLC is not in-network with any insurance company. I do **NOT** bill the insurance company. You will be given a statement that contains all the information needed to file your insurance for reimbursement. **Client is responsible for payment of fees, which will be collected at the time of service.**

Policy Holder's Name: _____ Date of Birth: _____
Insurance Company: _____
ID#: _____ Group#: _____
Employer: _____ SS#: _____
Insurance Company Phone #: _____
Relationship to Patient: _____

Emergency Contact

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

Name and Phone #:

_____

_____

OFFICE POLICIES AND PROCEDURES

This form provides information about our counseling relationship, procedures involved, and your authorized consent to treatment.

Length of Session: 50-60 minutes

Cost of Session: $165.00

Confidentiality: Your privilege of confidentiality will be kept as stipulated by law. Please see "Confidentiality" form attached for additional information/clarification.

Payment: The client is financially responsible for payment of fees, which will be collected at the time of service. Please see "Patient Information Regarding Professional Fees" form attached for additional information/clarification.

Cancellations: Your time is reserved for you. All appointments not cancelled twenty-four (24) hours in advance, BY PHONE, will be billed in full.

Consent: By seeing Samantha Ter Heege, MA, LPC, CART I understand that I and/or my minor child are giving fully informed consent to enter into a psychotherapy relationship.

I encourage you to address any questions or concerns you may have. Thank you!

I have read, understood and agree to the terms and conditions above.

_____ _____

Patient Signature **Date**

Informed Consent for Psychotherapy Agreement

SLT Therapy, PLLC recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The therapist will strive to help you grow toward greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapists work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

Therapist
The therapist is a licensed professional engaged in providing mental health care services to clients directly through SLT Therapy, PLLC. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

Appointments and Cancellations
Appointments are made by calling 281-784-3277, Monday through Friday between the hours of 8:00 am and 5:00 pm. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse you for missed appointments.

Number and Length of Sessions
The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors, and the therapist will discuss this with you.

Relationship
Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purposes, and Techniques of Therapy
There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

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 therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving your consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing Informed Consent and Privacy Practices forms, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

Risks of Therapy

Therapy is the Greek word for *change*. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy.

Payment for Services

SLT Therapy, PLLC will look to you for full payment of your account, and you will be responsible for payment of all charges. **I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE.** All cancellations should be **CALLED** into the office. Feel free to leave a message after hours and on weeks to avoid a late cancellation fee. Please be aware that insurance will not cover charges for missed appointments or late cancellations.

I am not in-network with any insurance company. I do **NOT** bill the insurance company. Providing me with your insurance information (card), and payment in full, will enable me to provide you with a standard insurance claim form (HCFA 1500), that you may choose to file with your insurance company for any out of network benefits you may have, payable to you.

Court
Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved. I understand that if I am involved in any legal action that requires testimony or deposition, that Samantha Ter Heege, MA, LPC, CART will charge a fee of $300 per hour portal to portal. This fee also includes time spent preparing for the testimony or deposition and making copies of any records involved. There will be a 3-hour minimum charge for any testimony or deposition.

After-Hour Emergencies
In the event of an emergency, contact/call 911 or go to the nearest emergency room.

Therapist's Incapacity or Death
In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent and Privacy Practices Receipt, you give your consent to another licensed mental health professional to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Consent to Treatment
By signing the Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

Contact Information
By signing the Informed Consent and Privacy Practices Receipt, you are consenting for SLT Therapy, PLLC to communicate with you by mail, e-mail, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise SLT Therapy, PLLC in the event of any change. You agree to notify SLT Therapy, PLLC if you need to opt out of any form of communication.

Notice of SLT Therapy, PLLC Privacy Policies

This notice tells you how we make use of your health information at SLT Therapy, PLLC, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the state of Texas to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice took effect on September 17, 2018 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at SLT Therapy, PLLC. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. *Here are some examples of how we use and disclose information about your health information*. We may use or disclose your health information:

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
6. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that is necessary to respond to the emergency.
7. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's

hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

***As a client of SLT Therapy, PLLC, you have these important rights*:**

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
B. You can ask us for photocopies of the information in part "A" above. There will be a $25.00 charge for copies made here. If you need copies of your health information due to a Third party request, we will charge a fee of $25.00 for the first 20 pages, then $.50 for each additional page.
D. You have a right to a copy of this notice at no charge.
E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. An example would be if you request that we contact you on an alternative phone number other than your residence. Your written request must specify the alternative means and location.
F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
G. You can make a written request that we amend the information in part "A" above.
H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or SLT Therapy, PLLC's, PLLC operations. This can go back as far as six years, but not before September 9, 2012.
K. If you request the accounting in "J" above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures.
L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Samantha Ter Heege, MA, LPC, CART 920 Frostwood, Suite 670, Houston, TX 77024. Telephone: 281-784-3277.
M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Receipt: SLT Therapy, PLLC

I, _____acknowledge that I have reviewed and received signed copies of the Informed Consent **and** Privacy Practices forms from SLT Therapy, PLLC.

Signature of Client: _____ Date:_____

Signature of Parent/Guardian, if Minor: _____ Date: _____

As witnessed by therapist: _____ Date: _____

CONFIDENTIALITY
PLEASE READ CAREFULLY

Generally speaking, communications between a patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law.

There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient. These occasions include, but are not limited to, the following:

- Belief that child abuse has or may occur
- Belief that an elderly or mentally handicapped person has been or may be abused
- Reports by a patient of possible sexual abuse or exploitation by a previous therapist
- Personal danger to self or an identifiable victim
- Testimony required by a judge
- Information provided to parents if the client is a minor
- Consultation with supervising professionals

Special rules apply to minors: By law, a parent has the right to the medical record of a child, unless this right has been limited by court action. Parents, on the other hand, may agree that during the course of treatment given to a minor child, they will waive the right to the medical record of their child. Such a waiver is often helpful for useful clinical work with a minor.

Additionally, advice may be elicited from professional peers in regard to your case, without revealing your identity.

If you have any questions, or would like additional information please feel free to ask.

ACKNOWLEDGEMENT BY PATIENT

I have read the preceding and understand my rights as a patient.

Patient Signature: _____ Date: _____

I am willing to waive my right of access to communication between my child and their physician/therapist and grant to the physician/therapist the discretion to determine when or if such communication would be shared with me.

Parent Signature: _____ Date: _____

Patient Signature: _____ Date: _____

PATIENT INFORMATION REGARDING PROFESSIONAL FEES

I understand that payment is expected at the time of delivery of service. I authorize Samantha Ter Heege, MA, LPC, CART or her authorized representative to charge my credit card.

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. All cancellations should be **CALLED** into the office. Feel free to leave a message after hours and on weekends to avoid a late cancellation fee. Please be aware that insurance will not cover charges for missed appointments or late cancellations.

IT IS CLEAR THAT THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS YOURS AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. I am not in-network with any insurance company. I do **NOT** bill the insurance company. Providing me with your insurance information (card), and payment in full, will enable me to provide you with a standard insurance claim form (HCFA 1500), that you may choose to file with your insurance company for any out of network benefits you may have, payable to you.

I understand that if I am involved in any legal action that requires testimony or deposition, that Samantha Ter Heege, MA, LPC, CART will charge a fee of $300 per hour portal to portal. This fee also includes time spent preparing for the testimony or deposition and making copies of any records involved. There will be a 3-hour minimum charge for any testimony or deposition.

Patient Name: _____

Cardholder Name: _____

Card Statement Address: _____

_____

____ MC ____ Visa Credit Card #: _____

Expiration Date: _____

CV#: _____Email Address: _____

Authorized Signature: _____ Date: _____

EMAIL AND TEXTING CONSENT

You may give permission to SLT Therapy, PLLC to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, and how we use email/text communication. I also will be used to document your consent for communication with you by email and test message.

1. **How we will use email and text messaging:** We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

2. **Risk of using email and text messages:** The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:
   a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Emails and texts can be used as evidence in court.
   g. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

3. **Conditions for the use of email and text messages:** SLT Therapy, PLLC staff cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
   a. **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call the office. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.

b. Emails should not be time-sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow up if we have received your email.
c. You should speak with your therapist to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
d. Email and text messages may be filed electronically into your medical record.
e. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
f. You should use your best judgment when considering the use of email or text messages for communication of sensitive medication information. Clinical staff are not responsible for the content of messages.
g. SLT Therapy, PLLC and its staff are not liable for breaches of confidentiality caused by you or any third part.
h. It is your responsibility to follow up with your therapist, if warranted.

4. **Withdrawal of consent:** I understand that I may revoke this consent at any time by so advising SLT Therapy, PLLC in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

5. **Client Acknowledgement and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between SLT Therapy, PLLC staff and me and consent to the conditions and instructions outlined, as well as any other instructs SLT Therapy, PLLC may impose to communicate with me by email or text message.

_____ _____

Patient Signature Date

_____

Signature of Parent or Legal Guardian, if Minor

PERMISSION TO OBTAIN SERVICES VIA SKYPE/FACE TIME

THIS INFORAMTION IS ENTIRELY CONFIDENTIAL

You have requested to receive services via Skype/Face Time. These are free, downloadable internet software applications that allow users to transmit video streaming over the internet, via webcam; and/or to share various kinds of files. To participate in this service, please provide the required permission and information on the form below:

Name of Patient: _____
Email: _____Phone: _____
Address: _____
City: _____State: _____Zip: _____

We take precautions in suing web cameras in an attempt to protect your privacy. However, since Skype/Pace Time are public series, you need to be aware that sending information over the internet does include the risk of personal information being accidently disclosed to other people (i.e., on the web). For this reason, we need your permission to utilize our services via Skype/Face Time.

___ Yes, I give my permission to utilize services via Skype/Face Time.

___ No, I do not give my permission to utilize services via Skype/Face Time.

_____ _____
Patient Signature Date

_____
Signature of Parent or Legal Guardian, if Minor

CREDIT CARD AUTHORIZATION

I have provided SLT Therapy, PLLC with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for all balances, all missed appointments and all insurance payments paid directly to me that were due this office. I understand that this form is valid unless I cancel the authorization through written notice to this office.

Client's Name: _____

Card Type: _____ Visa ____Mastercard ____ Discover

Credit Card Number: _____

Expiration Date: _____ CVC Code: _____

Card Holder's Name: _____

Card Holder's Signature: _____

Today's Date: _____

Assignment of Benefits

Assignment of Benefits Authorization

I hereby authorize payment to SLT Therapy, PLLC for the medical benefits otherwise payable to me, but not to exceed therapist's charge. I understand that I am financially responsible for charges not covered by this authorization.

I hereby authorize SLT Therapy, PLLC to release to my insurance company any clinical information that is required to assist with the filing of my insurance claim. This may include any clinical options, diagnosis, treatment plan and history information.

I further agree not to hold Samantha Ter Heege, MA, LPC, CART or her associates liable for the disclosure of such clinical information, as it is at my request that such be provided. I also understand that my insurance company will be requesting details and specific historical information, and hereby authorize release of such.

Benefit and authorization is a determination based upon medical necessity and is not a guarantee of claim payment. Payment determination will be made at the time a claim is received and will be based on eligibility, plan limits, plan exclusion and overall plan language.

All insurance benefits verifications are subject to final payment from your insurance company and are not the responsibility of this office.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Patient Signature Date

_____ _____

Parent Signature, if Minor Date

Authorization to Use/Disclose Information

I, _____ authorize _____and
{Name of Patient}

_____
{Name of Person(s) or Organization(s) which disclosure is to be made to and/or received from}

to disclose or release one to the other the following information from my records:

_____ All Health Care Information

_____ Health Care Information or Opinions Relating to Any or All of the Following Treatments and/or Conditions:

____ 1) Psychiatric or Mental Health Information
____ 2) Academic & Confidential School Information
____ 3) Testing
____ 4) Other _____

For the purpose of treatment/management and or supervision of psychological and/or medical condition(s), I **hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian, if Minor Date