Susan Martinez
MA, LMFT-S
Licensed Marriage & Family Therapist
Board Approved Supervisor

AGREEMENT FOR SERVICE/INFORMED CONSENT FOR PSYCHOTHERAPY/COUNSELING

Fee Arrangements

Payment is due at the beginning of each session. Cash (exact change) or check is preferred. Credit cards are also accepted. The usual and customary fee for outpatient therapy $120. Sessions are approximately 50 minutes. I reserve the right to periodically adjust this fee, with advance notice. In addition, this fee may be adjusted by contract with insurance companies or other third party payors or by agreement with me. Please be aware that insurance companies have restrictions on what they will cover and not all issues that may bring someone to therapy are covered by insurance. You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, and any other third party payor.

Cancellations

If you must cancel or reschedule an appointment, please leave a voicemail indicating so at least 24 hours in advance of your scheduled appointment or a $25 fee will be charged.

Confidentiality

Therapy sessions are confidential. There are some legal and ethical exceptions to this confidentiality including; danger to self and others, and suspicion of child, elder, and dependent adult abuse. No secrets policy for couples and families: Information shared with me by one participant will be open for discussion with the other participants, when clinically appropriate.

Emergencies

In the event of a life threatening emergency, please call 911 or go to your nearest emergency room.

Risks and Benefits of Therapy

Psychotherapy is a process in which we will discuss a myriad of issues for the purpose of creating positive change so that you can experience your life more fully. Psychotherapy is a joint effort. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thought and behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on your part, as well as family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some emotional discomfort. There may be times in which I will challenge the perceptions and assumptions of you and other family members, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. I do not make decisions about your life and your relationships for you. I will help explore and discuss issues and options, but you will make the decisions.

Technology

Technology assisted services are available when clinically appropriate. Video sessions are provided via Vsee using end to end encryption (FIPS 140-2 certified 256-bit AES encryption). You will receive an email invitation to connect with me on VSee if we have discussed and decided to use technology assisted services. Follow the instructions in the email to accept the invitation and sign up. It is compatible with most devices: Iphone Ipad, Android, Windows, PC,

and Mac. You will then be able to communicate with me by appointment via secure chat or secure video call. You can also securely send and receive documents and files via the chat feature. Attachments can be sent through chat. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering. Should there be a technical failure, please call me at 817-823-7311 (direct line) or I will call you at the cell phone number on file. I will determine on an on-going basis whether the condition being assessed or treated is appropriate for technology-assisted services. I have completed 18 credit hours in continuing education to engage in technology-assisted services and I complete an additional 2 hours every two years to remain current in technology assisted services. Technology assisted services provide convenience and access to services that may not otherwise be possible due to location or weather or other circumstances that may prevent you from coming to my office for a face to face visit. Records are maintained in a cloud based Electronic Health Record system (therapyappointment.com) for at least six years for an adult client and five years beyond the age of 18 for a minor. Therapyappointment.com is the cloud based Electronic Health Record (EHR) system that I use for encrypted, secure HIPAA and HITECH compliant records, notes, messaging and document storage.

Dual Relationships

I will avoid a therapeutic relationship with a personal friend, educational or business associate and will avoid the development of a personal, educational or business relationship with a therapy client.

Termination of Therapy

If at any point during therapy, I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time.

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute, in which you and another individual, or entity, are parties. It is agreed that should there be legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If compelled, the billing rate is $120/hr for all services including but not limited to: attorney consultation, document review, court testimony, wait time in court, report writing, case correspondence, travel time, and all other services relating to legal activities. Should my testimony or a report by required, payment of the equivalent of a one day retainer ($960) will be required in advance and must be attached to the subpoena along with appropriate written authorization from all persons who participated in therapy sessions. Cancellation of any court hearing or meeting will be charged a $120 cancellation fee for each cancellation or rescheduling with less than 24 hours notice.

Complaints

Complaints may be made to the Texas State board of Examiners of Marriage and Family Therapists at Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540. My license number is 201742.

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Acknowledgement

By signing below, you consent to treatment and acknowledge that you have reviewed and fully understand the terms and conditions of this agreement. You agree to abide by the terms and conditions of this Agreement and consent to participation in psychotherapy with me. Moreover, you agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. You understand that you are financially responsible to Therapist for all charges, including unpaid charges by your insurance company or any other third-party payor.

Adult Client Name Date of Birth Signature
Date

Adult Client Name Date of Birth Signature
Date

Minor Client Name Date of Birth Signature of parent/guardian Relationship to minor
Date

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FINANCIAL ARRANGEMENTS FOR PRIVATE PAY AND INSURANCE CLIENTS

Option A: For private pay clients, Health Insurance Waiver: I waive any insurance benefits for therapy sessions with Susan Martinez, MA, LMFT. She, nor I, will be filing insurance claims.

Date Signature

Option B: For insurance clients:
I am seeking therapy for medically necessary mental health concerns: individual or family sessions for symptoms of a mental health condition (e.g. anxiety, depression, behavioral, mood) that will be diagnosed by Susan Martinez and submitted to my insurance company for payment. I understand Susan Martinez will file the claims for primary insurance for me. I will file any secondary insurance myself, if applicable. I am responsible for any unpaid/noncovered services.

Date Signature

BEHAVIORAL HEALTH INSURANCE PLAN:
INSURANCE PHONE NUMBER:
PAYER ID (PREFERRED) OR ADDRESS TO SUBMIT CLAIMS:
INSURED ID #:
COPAY/CO-INSURANCE: DEDUCTIBLE:
Authorization number (only if preauthorization is required):

PATIENT NAME:
ADDRESS:
PHONE: SS# DOB:
SEX: Marital Status
Relationship of Patient to Primary Insured: (circle one) self child spouse

PRIMARY INSURED INFO (IF DIFFERENT THAN PATIENT):
NAME:
ADDRESS:
PHONE: SS# DOB
SEX Marital Status

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AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS FOR INSURANCE
(REQUIRED FOR INSURANCE CMS 1500 UNIVERSAL CLAIM FORM)

I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to Susan Martinez, MA, LMFT when she accepts assignment. I authorize payment of medical benefits to Susan Martinez, MA, LMFT for therapy services.

Date Signature

609 Cheek Sparger Rd Suite 104 Colleyville, TX 76034 817-823-7311

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the notice of privacy practices of Susan Martinez, MA, LMFT. My privacy practice notice provides information about how I may use and disclose health information that I maintain about you.

Adult Client Name	Date of Birth	Signature	
Date			
Adult Client Name	Date of Birth	Signature	
Date			
Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor
Date			
Minor Client Name	Date of Birth	Signature of parent/guardian	Relationship to minor
Date			

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Communication Preferences

If you have not done so already, please visit www.schedule.care to complete your bio form and complete and update your information in your file as well as to use features for online scheduling, appointment reminders, and secure messaging.

Please initial all acceptable methods of communication:

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message

_____ Via phone call

I understand the appointments reminders are available using non-secure means of communication and I understand the risks of non-secure methods of communication via email and/or text and that my information may be intercepted. I understand that secure means of communication is available via secure messaging through www.schedule.care. I authorize and consent the transmission of information regarding scheduling, billing, payment as indicated above. This authorization is valid until the earlier of the occurrence of the death of the individual or permission is withdrawn or the following specific date (optional) _____.

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Signature Date

609 Cheek Sparger Rd Suite 104 Colleyville, TX 76034 817-823-7311

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HIPAA NOTICE OF PRIVACY PRACTICES

The effective date of this Notice is September 1, 2013.

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or providing one to you at your next appointment. PHI is subject to electronic disclosure.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities, or collections.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect, Suicidal. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect, danger to self (suicide).

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include

government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent),court order, administrative order or similar, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health.If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Research.PHI may only be disclosed after a special approval process or with your authorization.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our **Privacy Officer, Susan Martinez, MA, LMFT at 817-823-7311.**

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer with any questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service for out of pocket. In that case, we are required to honor your request for a restriction.

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Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to a Copy of this Notice. You have the right to a copy of this notice.
COMPLAINTS If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at PO Box 571 Colleyville, TX 76034 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.