Family PsychSolutions, PLLC

9307 Broadway Suite 323

Pearland, TX 77584

(281) 902-1050

Thank you for choosing us as your healthcare provider. As with all your healthcare needs, we understand that you have a choice. Our services are designed to provide each individual with the appropriate help to reach their maximum potential. These services are delivered in a caring, professional, and family friendly environment that is sensitive to diverse health care beliefs and practices, encouraging the development of strong, healthy lives.

Please take the time to complete the following forms. Please provide as complete and accurate information as possible, so that we may ensure that you receive the best possible services.

Thank you for your cooperation.

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Consent for Treatment

Overview of Clinical Services

There are a number of different approaches that can be utilized to address the problems you are experiencing. I often use a variety of treatment modalities including individual, family, and couples therapy. When working with children, I may opt to use a technique known as play therapy. I typically use a form of therapy known as Cognitive Behavioral Therapy which involves changing one's thoughts, feelings, and behaviors regarding a situation. However, I may use other approaches depending upon your goals, personality, and other factors. We will work together to determine your goals and how best to treat them by developing a treatment plan. Your needs may change over time, which may necessitate a reevaluation of your treatment plan. Therapy requires a large commitment of time and energy on both our parts. In order to receive maximum benefits from therapy, you will have to work both during our sessions and at home.

Benefits and Risks

You may be asked to recall personal events that at times may be discomforting. It may result in increased levels of stress, anxiety, guilt, sadness, relationship disruption, escalation in undesired behaviors, and anger. As a result, you have the right to end therapy at any time. However, I may ask that we formally meet for one final session to discuss your feelings and alternative resources so that we may have closure. Despite risks, there are numerous benefits to therapy such as a reduction in the problems which led you to seek therapy, a reduction in problem behaviors, a reduction in the frequency or intensity of negative emotions, a reduction in stress levels, improved relationships, and improvements in your overall level of functioning and general well-being.

Office Policies

Therapy sessions generally last for 45 to 50 minutes. The initial appointment however may take longer so that I can get to know you and determine whether I am the best person to provide the services you need. After the initial appointment, we will schedule 45-50 minute sessions as needed or determined by the therapist. I am often not immediately available by telephone as I may be with a patient. Should you need to speak to me, please call (281) 902-1050. If I am unavailable, please leave a message and I will return your call as promptly as possible. If it is an emergency or in case you need a prompt response due to an urgent need, please visit the emergency room at the nearest hospital, call the police, or contact your family physician.

Testing appointments can range anywhere from 1 to several hours. Many times it depends on the referring question or the amount of services the insurance carrier authorizes.

Payment

If your clinician is an in-network provider with your mental health insurance carrier, the office will submit claims for payment on your behalf. Verification of benefits by our office is not a guarantee. Benefits are subject to change at any notice. You are responsible for any co-payments, co-insurance, and deductibles required by your health plan at the time of service. It is your responsibility to remit payment for charges not covered by your claim. You may be responsible for amounts your insurance does not pay. Payment is due in the form of cash, check, or credit card at the time services are rendered.

We charge $25 for any cancelled or returned checks or fraudulent credit card charge backs. Should you chose to not place a credit card on file, we ask that a deposit of $50 be made which will be reimbursed at the time services are terminated. A deposit will be asked each time a no show or cancellation occurs. Confidential information may be disclosed to collect monies owed. If suitable arrangements for payment have not been agreed upon and your account has not been paid for more than 60 days, I have the option of using legal means to secure payment, including but not limited to collection agencies or small claims court.

Your insurance may require authorization before they provide reimbursement for mental health services. They may also require the office to provide them with a clinical diagnosis, the type of service, and in some circumstances treatment plans or summaries, or copies of the entire record. I have no control over what the insurance provider does with the records. We will do our best to maintain your confidentiality. The office will assist you by completing our portion of a claim form. You are responsible for completing your portion as well as mailing it to the insurance company and tracking your reimbursement. We do not accept assignment of benefits from insurance carriers whose panels we are not affiliated with.

If I am required to participate in any type of court proceeding, you will be responsible for my participation even if you are not the party compelling me to testify. The rate of $100 per hour for time spent traveling, preparing reports, testifying, and any other case related costs will be applied.

It is the clients responsibility to notify us of any changes in benefits or insurance carriers.

Missed appointments

Please be as prompt as possible to sessions. If you are 30 minutes or more late to an appointment, you will be asked to reschedule. We allow two missed therapy appointments for any Medicaid clients before discharge is considered.

Confidentiality and Limitations to Confidentiality

All records are kept in a secured setting. All forms of communication between a client and therapist are protected by law. I can only release information to others with your written permission. However, there are a number of exceptions:

1) I am legally required to report to the proper authorities any allegations of abuse or neglect to a child, elder, or dependent individual.

2) If a disclosure of intent to harm is made, I am required to report that intention to the proper authorities. In order to ensure your safety and the safety of others I may contact the police, family members, or another medical facility to assist with hospitalization.

3) If a court order, other legal proceedings, or statute requires disclosure.

4) To your mental health insurance carrier to handle claims.

5) Supervision is required for any provisionally licensed clinician or clinician in training.

Minors

In providing therapy services to minors, confidentiality is a necessity to ensure a trusting relationship and safe environment. While you as a parent or legal guardian have a legal right to information, I will convey general information to you about the status of treatment such as how treatment is proceeding unless there is a danger to the minor's life. Information such as risky sexual behavior, harmful substance use, eating disorders, criminal activity, and other dangerous lifestyle choices may be disclosed in addition to the limits of confidentiality noted above. Sometimes these behaviors are normal adolescent experimentation. Other times they may require parental intervention. I may ask the parent or legal guardian and minor to meet together to discuss the matter, any objections, and to voice concerns. If any parent or guardian, decides to abruptly discontinue therapy I ask that you allow me the option of having a closing session to appropriately end the therapeutic relationship. If a child custody proceeding occurs, I will not give an opinion about either parent's custody or visitation suitability. I may choose to not participate unless court ordered. I may then provide information as needed on behalf of the child's best interests. If I am required to participate in court proceedings, the party responsible for my participation agrees to reimburse me at the rate of $100 per hour for time spent traveling, preparing reports, testifying, and any other case related costs.

I, have read and fully understand the information provided. I agree to abide by the conditions of this contract. Your signature acknowledges the agreement and understanding.

_____

(Print Minor's Full Name)

_____ DATE:_____

(Signature of Parent or Legal Guardian)

_____ DATE:_____

(Signature of Therapist)

Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

this notice will explain how we handle your mental health information. Applicable federal and state laws require us to maintain the privacy of clients personal and health information. In this notice your personal or protected health information is referred to as" PHI" and includes information regarding your health care and treatment with identifiable factors such as your name, age, address, or financial information. Family PsychSolutions, PLLC protects your health information by treating all of your health information as confidential (unless noted in the confidentiality clause involved in consenting to treatment), by treating all staff in federal and state confidentiality policies and practices per HIPAA, by restricting access to your health information only to those office staff that needs to know your health information in order to provide services to you, and by maintaining physical electronic and procedural safeguards to comply with federal and state regulations guarding your health information.

Family PsychSolutions, PLLC may use or disclose your PHI for treatment, payment, and healthcare operation purposes if you have given consent to receive an evaluation, consultation, or treatment services. Treatment occurs when the office provides, coordinates, or manages your health care and other services related to your healthcare. An example of treatment would be one or office consults with another healthcare provider, such as your family physician. Payment involves providing reimbursement for the services received in the office. An example of payment would be when our office discloses your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility for coverage. We may disclose information to determine eligibility or coverage, for billing, claims management, collection activities, and utilization review. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered. Health care operations are activities that relate to the performance and operation of our office. Examples are quality assessment and improvement activities, business related matters such as audits and administrative services, case management, care coordination, and conducting training and educational programs. Use involves activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Disclosure are activities outside of the office such as releasing, transferring, or providing access to information about you to other parties.

Family PsychSolutions, PLLC and any of its administrators may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your authorization is obtained and authorization is written permission above and beyond the general consent that permits

only specific disclosures. In those instances when the office is asked for information for purposes outside of treatment, payment, or health care operations we will obtain authorization from you before releasing this information. You may revoke all such authorization at any time, provided each invocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However we cannot take back any information already disclosed with your permission or that we had used in our office.

The law lets Family PsychSolutions, PLLC use or disclose PHI without your consent or authorization in some cases. Authorization is not needed when required by law. For example suspected child, elder, or dependent abuse must be reported also, if you are involved in a lawsuit or legal proceeding in the provider receives a subpoena, discovery request, or other lawful process, some of your PHI may have to be released. Finally, some information has to be disclosed to governmental agencies, which checked providers to see that privacy laws are being obeyed. Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal. Some of your PHI might be disclosed for public health activities such as when agencies investigate diseases or injuries. PHI may be disclosed to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants. Protected health information can be disclosed for specific government functions. For example PHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PH I may also be disclosed to workers compensation and disability programs, to correctional facilities if you're an inmate, and for national security reasons. PHI can't be disclosed to prevent a serious threat to health or safety. If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI. This disclosure will only be provided to persons who can prevent the danger. In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. PHI can be released to show compliance with HIPAA, for research purposes, or if a licensing board or accredited body is investigating an office you filed a formal complaint against.

Patients have the right to request that the provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. You have the right to receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address. If you have the right to inspect and/or obtain a copy of your records a reasonable fee may be charged for copying. We may take up to thirty days to provide you with the information you request. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you

the details of the requests and denial process. You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. We will reply within sixty (60) days of the request. If the request is denied, a written explanation stating the reason why will be provided to you. You may also make a statement disagree with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted. You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the rights when accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of the person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one accounting is requested in a twelve (12) month period, a reasonable fee may be charged. If you received this notice electronically (e.g. accessing a website) you have the right to obtain a paper copy of this notice from the office upon request.

The provider is required by law to maintain the privacy of PHI is to provide you with this notice of legal duties and privacy practices. Family PsychSolutions, PLLC reserves the right to change the privacy policies and practices in terms of this notice at any time, as permitted by applicable law. Family PsychSolutions, PLLC reserves the right to make the changes in privacy practices and the new terms or notice effective for all health information that we maintain, including health information we created or received for remake changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

For questions regarding this notice of privacy practices, or if you're concerned that your privacy rights may have been violated, please contact Daniela M. Costa, Ph.D. you may also make a written complaint to the U.S. Department of Health and Human Services, whose address can be found below. If you choose to make a complaint with the U.S. Department of Health and Human Services, or with your provider, Family PsychSolutions, PLLC will not retaliate in any way.

The US Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
1(877) 696-6775

By signing this consent form you acknowledge that a copy of the notice of privacy practices has been displayed and/or provided to you and consent to our use and disclosure of PHI for treatment, payment, or health care operations as described in this notice of privacy practices.

You have the right to revoke this consent in writing any time, except where we have already used or disclosed your health information in reliance upon this consent.

_____ Date: _____

Patient Name

_____

Patient Signature or Signature of Legal Representative

CONSENT FOR RELEASE OF CONFIDENTIAL CLIENT INFORMATION

This consent authorizes: _____
(Facility/Organization/Individual)

_____
(Mailing Address)

_____
(Phone/Fax Number)

To exchange/release the following information on: _____
(Client Name and Date of birth)

From/To: Family PsychSolutions, PLLC, Provider: _____

For the purpose of: ❑ Disability Determination ❑Insurance Claim ❑Care by another provider ❑Other: _____

The information to be disclosed is:

❑Discharge Summary
❑Initial Intake
❑Disability Determination Evaluation
❑ Other:
❑Psychological Evaluation
❑Progress Notes
❑Treatment Plan
❑Educational Assessment

_____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. This consent will expire in a year from the day signed or the date of discharge.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in the consent and any other use of this information without the expressed written consent of the client is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2). Information to be disclosed may include sexually transmitted diseases, HIV/AIDS, mental illness, and substance abuse. Communication can include both written and verbal.

_____ _____
Client/Guardian Signature Date

_____ _____
Examiner Signature Date

The clinician will provide services in a professional manner consistent with all applicable laws, rules, regulations, guidelines, and codes of ethics concerning the therapist and the therapist/client relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist. If you do not believe your complaint was handled in a satisfactory manner please contact Dr. Costa, the owner of Family PsychSolutions, PLLC at (281) 902-1050. Depending upon the clinician's credentials, you may also formally file a complaint about a clinician to:

Texas State Board of Examiners of Professional Counselors

1100 West 49th Street

Austin, TX 78756-3183

(512) 834-6658

Texas State Board of Social Worker Examiners

PO Box 141269

Austin, TX 78714-1369

(512) 719-3521

Texas State Board of Examiners of Psychologists

333 Guadalupue Suite 2-450

Austin, TX 78701

(512) 305-7700

By signing below, I acknowledge that I have read, understood, and agree to everything in this agreement

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Staff Signature Date

I have provided Family PsychSolutions, PLLC with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for psychotherapy services, psychological evaluations, missed appointments, balances, and insurance claims.

My credit card will be charged each time a service is provided unless I decide to pay in cash or via check. In the event that my insurance does not cover all expenses, I am responsible for amounts they do not cover after the office's attempt to recoup. For your convenience, Family PsychSolutions will wait a reasonable amount of time to be reimbursed by your insurance carrier for services delivered. I am giving Family PsychSolutions permission to charge my credit card for any services that have not been paid by myself or my insurance carrier within sixty (60) days of billing. If services have not been paid within 60 days, Family PsychSolutions will notify me in writing that they have not been paid by my insurance carrier and they will encourage me to contact the carrier in order to get them to pay for the services in a timely manner. We charge $25 for any cancelled or returned checks or fraudulent credit card charge backs. Confidential information may be disclosed to collect monies owed. If suitable arrangements for payment have not been agreed upon and your account has not been paid for more than 60 days, I have the option of using legal means to secure payment, including but not limited to collection agencies or small claims court.

Unfortunately, we do not accept AMEX.

I understand that this form is valid for one year unless I cancel authorization through written notice to Family PsychSolutions, PLLC. By signing below I acknowledge that I am the card holder and responsible for payments in accordance with this document.

Name On Card: _____

Type of Card (visa, discover, master card): _____

Card Number: _____

Expiration Date: _____

Zip code affiliated with credit Card: _____

Card Holders Signature: _____

Date: _____

CHILD QUESTIONNAIRE

CHILD'S NAME: _____ DATE: _____

DATE OF BIRTH: _____

NAME OF PERSON GIVING INFO: _____

THEIR RELATIONSHIP TO CHILD: _____

CURRENT LIVING ARRANGEMENTS
CHILD LIVES WITH: _____

CHILDHOOD HISTORY
PLACE OF BIRTH: _____

PLACE WHERE RAISED: _____

NAMES AND AGES OF BROTHERS AND SISTERS:

_____

_____

WAS THE CHILD'S PARENTS EVER MARRIED?

- ☐ YES
- ☐ NO

MY MAIN CONCERN ABOUT MY CHILD IS:

_____

_____

_____

DATE THE CHILD'S PROBLEMS BEGAN: _____

MY CHILD'S STRENGTHS: _____

DEVELOPMENTAL HISTORY
DESCRIBE ANY COMPLICATIONS DURING PREGNANCY/BIRTH: _____

_____

WAS THE CHILD BORN ON TIME?

- ☐ YES
- ☐ NO

WAS THE CHILD EXPOSED TO DRUGS BEFORE BIRTH?

- ☐ YES
- ☐ NO

CHILD'S DEVELOPMENT IN GENERAL: ❑ ON TIME ❑ ALL DELAYED ❑ ONLY SOME AREAS DELAYED

DEVELOPMENTAL MILESTONES: (check only those the child did not do at expected age)

❑ SITTING
❑ WALKING
❑ SINGLE WORDS
❑ TWO/THREE WORDS
❑ TALK IN COMPLETE SENTENCES
❑ TOILET TRAINED (BLADDER)
❑ TOILET TRAINED (BOWEL)
❑ WRITING
❑ SEPARATE FROM PARENTS WITH NO DIFFICULTIES

SCHOOL INFORMATION

CURRENT GRADE IN SCHOOL: _____

NAME OF SCHOOL: _____

CLASS PLACEMENT:

❑ REGULAR CLASSES ❑ SPECIAL CLASSES (type): _____

GRADES LAST REPORT CARD: _____

FREQUENT SUSPENSIONS OR EXPULSIONS?

☐ YES (REASON: _____)
☐ NO

DID THE CHILD REPEAT A GRADE IN SCHOOL?

☐ YES (WHICH GRADES?:_____)
☐ NO

MEDICAL HISTORY

MAJOR ILLNESSES_____

MEDICATIONS CURRENTLY TAKING (including mg): _____

_____

MEDICATIONS TAKEN IN THE PAST (including mg): _____

_____

HOSPITALIZATIONS / SURGERIES (DATES AND REASON)

_____

_____

MENTAL HEALTH HISTORY

HAS THE CHILD EVER BEEN HOSPITALIZED FOR A MENTAL HEALTH PROBLEM?

☐ YES (describe): _____
☐ NO

PAST COUNSELOR/THERAPIST: _____

PRESENT PSYCHIATRIST: _____

PAST PSYCHIATRIST: _____

PRESENT PSYCHIATRIC MEDICATION (include mg): _____

_____

PAST PSYCHIATRIC MEDICATION (include mg): _____

_____

FAMILY HISTORY

FAMILY MEMBERS WITH HISTORY OF PSYCHIATRIC OR EMOTIONAL PROBLEMS: (list relationship to child, type of problem, any treatment received)

_____

_____

FAMILY MEMBERS WITH HISTORY OF LEARNING PROBLEMS: (list relationship to child, type of problem, any treatment received)

_____

_____

FAMILY MEMBERS ON PSYCHIATRIC MEDICATION: (list relationship to child, type of medication)

_____

_____

FAMILY MEMBERS WITH HISTORY OF DRUG/ALCOHOL ABUSE: (list relationship to child, any treatment received)

_____

_____

SOCIAL RELATIONS

HOW DOES YOUR CHILD GET ALONG WITH CLASSMATES? _____

_____

HOW DOES YOUR CHILD GET ALONG WITH FRIENDS OUTSIDE OF SCHOOL? _____

_____

HOW DOES YOUR CHILD RELATE TO FAMILY MEMBERS? _____

_____

RISK BEHAVIOR

HAS YOUR CHILD EVER THREATENED TO HARM HIM/HERSELF?

❑ NO ❑ YES (please provide details) _____

_____

HAS YOUR CHILD EVER ATTEMPTED TO HARM HIM/HERSELF?

❑ NO ❑ YES (please provide details) _____

HAS YOUR CHILD EVER THREATENED TO HARM OTHERS?

❑ NO ❑ YES (please provide details) _____

_____

HAS YOUR CHILD EVER ATTEMPTED TO HARM OTHERS?

❑ NO ❑ YES (please provide details) _____

_____

HAS YOUR CHILD BEEN INVOLVED WITH THE POLICE OR JUVENILE COURT?

❑ NO ❑ YES (please provide details) _____

_____

ABUSE/NEGLECT

HAS THE CHILD EXPERIENCED ABUSE OR NEGLECT?

☐ YES (DESCRIBE: _____)

☐ NO

WORK HISTORY

❑ CHILD HAS NEVER WORKED OUTSIDE OF THE HOME

❑ CHILD HAS WORKED OUTSIDE OF THE HOME. (please provide details) _____

_____

_____

MAY WE CONTACT YOUR CHILD'S PRIMARY CARE PHYSICIAN?

☐ YES (Name and phone #: _____)

☐ NO

OTHER INFORMATION THAT IS IMPORTANT TO KNOW ABOUT MY CHILD

_____

_____

_____

_____

_____