CY-HOPE COUNSELING
The Center for Children and Families

12715 Telge Rd.
Cypress, TX 77429
713.466.1360
www.cy-hopecounseling.org

Qualifications

I am pleased you have selected me as your speech language pathologist Assistant. This document is designed to inform you about my background and to ensure that you understand our professional relationship. I hold a license from the State of Texas as a Speech Language Pathologist Assistant. I hold a Bachelor of Science degree in Communication Sciences and Disorders from University of Texas. My specialties include working with receptive/expressive language delays, fluency disorders, and pragmatic and social language difficulties. I also have expertise in articulation and phonological processes disorders, where someone may be pronouncing words incorrectly or omitting consonants leading to a reduced intelligibility.

Referrals

If you become dissatisfied with my services at any time, please let me know. It is my obligation to provide a list of other professionals that may be of more help to you.

Center Policies

It is Cy-Hope Counseling's policy that any child age 12 and younger have a parent or adult guardian remain onsite for the entire counseling session.

If a client cancels and/or does not show to 3 consecutive appointments, Cy-Hope Counseling reserves the right to change the client's therapist and/or appointment time.

Records and Confidentiality

The law protects the privacy of all information obtained during the counseling process. In most situations, Cy-Hope Counseling can only release information about a client if the client, a parent, or guardian signs a written Release of Information. A Release of Information is specific to an individual, another professional, school or agency. You should also be aware that, pursuant to Texas law, any test data can only be released to trained mental health professionals.

There are some situations where Cy-Hope Counseling is permitted or required to disclose information without either a consent or a Release of Information. These include:

1. If a client is involved in a court proceeding and a request is made for information concerning the client. Cy-Hope Counseling cannot provide any information without the client's or client's legal representative's written authorization. However, if Cy-Hope Counseling receives a court order, Cy-Hope Counseling may disclose information without the client's consent or authorization. If the client is involved in or contemplating litigation, the client should consult his/her attorney to determine whether a court would likely order Cy-Hope Counseling to disclose information.
2. If the client's records are subpoenaed as part of a criminal investigation, Cy-Hope Counseling must disclose the client's records without the client's consent or authorization.
3. If a client files a complaint or lawsuit against Cy-Hope Counseling, Cy-Hope Counseling may disclose relevant information regarding the client without the client's consent or authorization in order to defend itself.

There are some situations in which Cy-Hope Counseling is legally obligated to take action. These include:

1. If Cy-Hope Counseling has cause to believe a child under age 18 has been or is at risk to be abused or neglected (e.g. physical injury, a substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct) or that a child is a victim of a sexual offense, the law requires Cy-Hope Counseling to make a report to the appropriate governmental agency. This is usually the Texas Department of Family and Protective Services. Once such a report is filed, Cy-Hope Counseling may be required to provide additional information to this agency.
2. If during the course of counseling Cy-Hope Counseling learns that a client has been sexually abused or exploited by a mental health professional, state law requires Cy-Hope Counseling to report this information to law enforcement and the professional's licensing board.

3. If Cy-Hope Counseling determines that there is a probability that the client is in imminent danger of harming himself/herself or others, Cy-Hope Counseling may contact family members or others (e.g. medical, mental health, or law enforcement personnel) to provide protection for the threatened individuals.

I will keep a written record of our own sessions. Some sessions may be audio and/or video-taped. This is for the protection of both parties involved and will be kept confidential. It is my intention to render my services in a professional manner consistent with the accepted standards of practice. Please note that after 30 days without contact between us, Cy-Hope will no longer consider you a client. Should you wish to return for services, you will begin the intake process again.

Individual counseling sessions typically run 45 – 50 minutes. Play therapy sessions generally are 30 – 45 minutes. Your consideration in arriving **on time for your scheduled appointment is greatly appreciated**. In the event of a cancellation, **24 hours prior notice is necessary** to avoid being charged for the session. Fees for various counseling services are noted on the attached *Fee Schedule*. Payment is due at the time service is provided.

May we acknowledge by correspondence the person or agency whom referred you? **Yes No**

Who may we thank for referring you to Cy-Hope Counseling? ______________________________

Please sign and date this form showing that you agree to the terms above.

______________________________ ______________________________

Client/Parent/Guardian Signature Date Therapist Signature Date

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Patient Information Record

Patient Name (first, middle, last): ____

Date of Birth: _____ /______ /________ Sex: Male Female Age: _______________

Race:______________________ Ethnicity:____________________ Language Preferred:_____________________

Grade, if applicable:_____________________ School, if applicable: ______________________________

Street Address: __________________________City: ________________St: ____ Zip: _____________

Primary Phone: _______________________ Cell Phone: ________________ Texting OK? Yes No

Email: _______________________________________

(if patient is a minor, please fill in parent information for below)

Parent Name

____

Address: __________________________

____

City State Zip

Email: _____________________________

Primary Phone: _______________________

Cell Phone: __________________________

Texting OK? Yes No

Parent Name

____

Address: __________________________

____

City State Zip

Email: ____________________________

Primary Phone: _____________________

Cell Phone: _________________________

Texting OK? Yes No

<u>Party Responsible for billing</u>:

Name: __________________________ Relationship to patient: __________________

Social Security #: ______-_____-_______ Driver's License #: _______________________

I understand that I am responsible for all amounts due at the time of service. I understand Cy-Hope Counseling does not file insurance on your behalf. However, you will be provided with an itemized statement in order to file for insurance reimbursement on your own.

____
Signature

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
Relationship to patient:
Signature:
Date:

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	Initials:	Reason:

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FEE SCHEDULE

Initial Assessment	Initial interview, collection and assessment of data. Request for records from previous providers.	$90
Individual Session	45 – 50 minutes per session	$90
30 Minute Therapy Session	30 minutes per session	$60
Group Speech	60 – 90 minutes per session	$30-50
Consultation	Per hour to schools, parents, agencies etc…	$90
Telephone Consultation	Over 10 minutes – No more than 50 minutes	$90
Preparation of Documents	Work/School/ or other individual or organization as requested. (Minimum of 1 week notice must be given; Does not include school/work excuse forms	$90/hour

BILLING POLICY

1. Appointments must be cancelled **24 hours in advance** or client **will be charged** the full session fee**.** Payment for sessions cancelled without notice is expected prior to scheduling the next appointment.

2. Fees are to be paid at the time services are rendered. Cash, check , Master Card or Visa are accepted.

3. An encounter form, verifying client's payment for session, is provided should client wish to file an insurance claim.

4. The client or responsible party is ultimately responsible for any fee for services rendered.

I, the undersigned, have read and do agree to the above fee and billing policies of this office.

______________________________ __________________________
Signature (Responsible Party) Date

___________________________________ __________________________
Signature (Witness) Date

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Court Related Fees and Services

□Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $750.00 is due before any court related services are provided
□Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
□It is required that a minimum of 36 hours notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
□Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.
□In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

I understand that my fee will be $__________ for each counseling session or $__________ per hour for court related services

______________________________ ____________________
Signature (Responsible Party) Date

______________________________ ____________________
Signature (Witness) Date

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Parental Consent Form

(For persons under 18 years)

________________________________has my/our permission to participate in the speech therapy services provided by Halle Finkley, SLP-A. I/we understand that all materials (interview information, test scores, audio/video tapes, and other personal data) will remain confidential and will not be released to any other agency or person without my/our written consent. My/our written consent to allow the above named person to participate in these counseling services does not waive any of my/our legal rights.

________________________________	________________________________
Parent/Guardian	Address
________________________________	________________________________
Parent/Guardian	City/State/Zip Code
________________________________	________________________________
Date	(Area Code) Phone Number

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CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

In most cases, we feel it is to your advantage that we work with your doctor(s) or others who may have a role in your care. If your therapy concerns a child, it is often helpful for us to have contact with his or her school counselor, teachers, and/or principal.

In order to communicate with these people about you and/or your child, we need your permission. Please sign the release of information below, which allows us to discuss you and/or your child with these people, and/or mail letters/reports to them.

I, ______________________________ (print name) authorize the following mental health care provider and/or organization to disclose and/or use the following confidential patient information to the designated person and/or organization for the purpose(s) listed below.

Information disclosed by:	**Information received by:**
Cy-Hope Counseling ______________________________ (name of provider/organization) ______________________________ (address) ______________________________ (city, state, zip) ______________ ______________ (fax number) (phone number)	______________________________ (name of provider/organization) ______________________________ (address) ______________________________ (city, state, zip) ______________ ______________ (fax number) (phone number)
How would you like the information sent? **_________ To be mailed** **_________ To be picked up by ______________________** **_________ To be sent via fax**	**For the purpose of: (please state) <u>This request and authorization applies to only the following protected health information</u>:** **______ CONSULTATIONS** **______ PROGRESS NOTES/SUMMARY** **______ PSYCHOLOGICAL REPORTS/EVALUATIONS** **______ BILLING REPORTS** **______ TREATMENT PROGRESS** **______ OTHER**

I understand that I may revoke this consent at any time (except to the extent that disclosure has already occurred in reliance upon this consent) by sending a written revocation to the organization designated above.

Otherwise, this authorization is given:
________ During the following time period or dates: ______________________________ *OR*
________ Until Termination of Counseling

I understand any information disclosed by this authorization to any person/organization not a health care provider covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.

To the receiving party of this information: this information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed consent of the patient is prohibited. These records may be protected by federal regulation (42 CFR part 2).

____
(Patient's Signature) or (Parent/Guardian or Authorized Representative) (Date)

____
(Witness Signature) (Date)

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Credit Card Authorization

It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modifications. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time you will be charged a full session fee. If a check is returned unpaid, you will be charged the full session fee. An additional $25 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Please list **ALL** clients and their date of birth to be authorized to charge session fees on the card listed below:
Client name/s and date of birth: ____
Address: ______________________City: _____________ St: ______ Zip: ________
Home Phone: _____________________ Mobile Number: ___________________
Email: ____

I, ___________________________, hereby authorize Cy-Hope Counseling to bill my credit card at the usual fee for professional services including all the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email or Skype consultations
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks
- Fees not covered by insurance or insurance payments make to patient rather than provider

Cardholder Information: Please indicate the name and address associated with the credit or debit card you wish to use.

Name on card : ______________________________________
Address only needed if CC billing address is different than address listed above.
Address: ______________________City: _____________ St: ______ Zip: ________
By signing this form I am authorizing Cy-Hope Counseling to bill my credit card or debit card ending in _______ (provide last 4 digits of the card) at the usual fee for professional services. I will not dispute charges ("Charge Backs") for sessions I have received or appointments I have missed according to the above policy.

__________________________ ______________
Cardholder signature Date

____
Print Name

Card Type (circle one): **Visa** **MasterCard** **Discover**
Card # ____________________________________ Expiration Date: __________
Verification/Security Code (3 digit code on back of card by signature line): ______