Carolyn M. Bates, Ph.D.
Licensed Psychologist and Independent Contractor
4131 Spicewood Springs Road, Suite K-8 * Austin, Texas 78759 * (512) 346-3788

CLIENT INFORMATION

NAME DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL PHONE SOCIAL SECURITY NUMBER

YES NO
OCCUPATION/SCHOOL EMPLOYER WORK PHONE (May you be called at work?)

MEDICATIONS YOU ARE CURRENTLY TAKING

YES NO
PHYSICIAN PHONE (May s/he be contacted if needed?)

PERSON TO CONTACT IN CASE OF EMERGENCY PHONE RELATION TO YOU

SIGNIFICANT OTHER/PARTNER NAME IF APPLICABLE MARITAL STATUS

INSURANCE COMPANY

GROUP NO. OR NAME POLICY NO.

POLICY HOLDER RELATION TO YOU POLICY HOLDER'S DATE OF BIRTH & SS#

NAME OF RESPONSIBLE PARTY: _____
ADDRESS: _____
CITY/STATE/ZIP: _____

I hereby give consent to have information regarding my diagnosis and treatment given to my insurance company, managed care company, and/or my EAP representative. I understand that once this information has been disclosed, my therapist cannot guarantee that the insurance company, managed care company, and/or the EAP representative will handle the information in a confidential manner under the HIPAA Privacy Rule. I understand that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify Dr. Bates of any changes in my health status or the above information.

_____ _____
Signature of Client Date

Form updated: 1/2009

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CLIENT INFORMATION

Release of Information

Your privacy is important to me and I want to protect your personal health information. Please check below to whom I may release information. You have the right to revoke this permission at anytime by communicating your desire to me either in writing or orally.

___ My physician

___ My spouse

___ My family, please identify_____

___ My attorney, please identify

___ My children, please identify_____

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CLIENT INFORMATION AND PSYCHOLOGICAL TREATMENT CONTRACT

The Initial Consultation

In your initial consultation we will discuss your reasons for seeking psychotherapy and what treatment options might best help you. If scheduling does not allow us to work together, or if either you or I believe you will be better assisted by working with another therapist, I will be happy to offer you referrals.

Limits of Confidentiality

In accordance with Texas law and ethical standards for psychologists, information you share with me is confidential, *with the exception of a few specific situations that include*:

A. Situations required by state law: Instances of actual or suspected child abuse, elder abuse, abuse of the infirm or neglect must be reported to the Protective Services division of the Department of Human Services. In cases of abuse that have already been reported, I may request a copy of the case dispensation from the caseworker. I must report patient abuse or neglect in any psychiatric hospital or chemical dependency treatment program for which I am an Allied Professional Staff member.

B. Psychiatric or medical emergencies: If I believe someone is in imminent danger of suicide or homicide, I am required to take protective actions. This may include notifying the appropriate medical or law enforcement personnel and seeking hospitalization for the client; it may also include notifying the emergency contact your provide me in your intake papers.

C. Court orders: These may occur in child custody or divorce litigation.

D. If you are a complainant or a plaintiff in a lawsuit: Where you allow the question of your mental health to be a factor in a complaint or lawsuit, you will have already automatically waived your right to the confidentiality of your records in the context of that complaint or lawsuit. In spite of that, I will not release information without your signed consent or a court order. You may also discuss with your attorney obtaining a protective order to help maintain confidentiality of your records.

E. Sexual exploitation by a health care provider: If you have been sexually abused or exploited by a physician, therapist, spiritual counselor, or other health care professional, I must report this to the appropriate licensing agency and to the District Attorney's office. You may request that your name be kept anonymous in such a reporting situation.

F. When you sign a release of information of your records: This directs me to share that information with another party whom you have named in the release of information.

G. Nonpayment for services: This would require that I give your name to a collection agency to seek payment for monies due.

H. **In the case of incapacity to render services**: I do maintain a "professional will." In the case of my permanent disablement or death, your records will be transferred to a psychologist who will oversee contacting you to determine if you would like a referral. He/she will also oversee the transfer of your records to a clinician of your choosing.

Appointments

Individual therapy sessions are generally scheduled on a weekly basis and last 50 minutes. Successful therapy depends upon both your presence and promptness. Because your session time is reserved for you, *I charge for missed sessions if not given 24 hours' notice of cancellation. To avoid being charged for broken or missed appointments, you must give* at *least 24 hours' notice for cancellation.* I cannot bill your insurance carrier for missed appointments.

Professional Fees

To avoid misunderstandings, please understand that you are responsible for payment of my professional services. My fee is $155.00 per 50-minute session. I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than five minutes, attendance at meetings with other professionals that you have authorized or have been required on your behalf, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, and testimony. Because of the difficulty of legal involvement, my fee for preparation and attendance at any legal proceeding is $240.00 per hour if I am called as an expert witness; if I am called to testify as a fact witness, my regular fee applies.

Length of Treatment
Length of treatment will vary in part as a function of presenting concerns and issues that may arise during the course of treatment. Jungian analytic treatment is typically long-term treatment focusing on underlying patterns of belief and behaviors that may contribute to difficulties you are facing in your life.

Billing and Payments
Payment is due at the time a session is held, unless we agree otherwise or unless I bill your insurance on your behalf. In circumstances of unusual financial hardship, I may be willing to negotiate a temporary fee adjustment or payment installment plan for a period of three months. Cash or checks are accepted for payment.

Insurance Reimbursement
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Health insurance usually provides some coverage for mental health treatment. If I am not a preferred provider for your insurance company, I will provide you with a receipt of payment that you may file with your company. However, you, not your insurance company, are responsible for full payment of my fees. I recommend that you carefully read the section in your insurance coverage booklet that describes mental health services so that you are informed about your insurance plan's rules regarding deductibles, co-payments, limits of coverage, and what conditions and therapies are covered. It is important for you to understand that to have your insurance cover mental health services you will be given a mental health diagnostic code that best reflects the symptoms you describe.

Managed Care Plans
I currently contract with very few any managed care plans. If your insurance company requires that I submit treatment plans and billing paperwork for you to be reimbursed, please understand that I charge for the time required to do this. Most insurance companies require you to authorize me to provide them with a clinical diagnosis. You should be aware that this information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with confidential information once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I am required to submit, if you request it.

Managed care plans often require pre-authorization before they provide reimbursement for mental health services. They may require me to seek approval for more therapy after the initial number of authorized sessions. I do charge for claims denied by your managed care company or insurance company. These plans are usually limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. If you decide you want more treatment than your managed care company supports, you have the option of using fee-for-services. Many people seek psychotherapy or analysis to help them make long-lasting changes in ineffective or counter-productive coping styles at work or in relationships; a typical course of psychotherapy for such life changes may cover a period of six months to a year or more. If you feel you would like this kind of assistance, fee-for-service may be necessary.

For Patients Using Medicare
Patients using Medicare as a form of insurance are hereby informed that Carolyn M. Bates, Ph.D. has opted out of being a service provider for Medicare effective April 1, 2009.

Maintaining Professional Service
In the interest of continued professional development and integrity of treatment, I engage in supervision and consultation as I see a need to; if I see a need to do so with your case, please know that I will change identifying details *to assure that your identity will remain confidential*.

Continued Sessions
I generally do not schedule appointments following the third session in which payment is not received, unless prior arrangements have been made. This policy is maintained so that I may remain fiscally sound and therefore able to provide consistent quality service, and to assist you in avoiding a burden of financial debt.

Record Holding and Contact by Another Professional

As a psychologist I hold the ethical responsibility to assure the transfer of care of my clients should I become disabled or in the event of my death. Arrangements have been made with another licensed psychologist to contact you, see to the transfer of your case, and hold my records in case of my disability or death. Your signature below conveys that you understand that your records would be transferred to and held by another mental health professional should this need ever arise. Less grimly, when I am away on vacation or at conferences, your calls to my office may be returned by the mental health professional on backup for me. If I am delayed in returning from time out of the office due to travel delays or unexpected events, you may be contacted by the mental health professional on backup for me.

Emergencies: You may reach me in case of an emergency by calling 512/346-3788. I will return your call as soon as possible. If during an emergency you are unable to reach me quickly enough, you may call the mental health hotline (472-HELP) which provides around-the-clock telephone crisis counseling and information. If your situation is life threatening you should call 911, your family physician, your psychiatrist if you are under the care or one, or go to the nearest emergency room.

Your signature below indicates that you have read the information in this document and that you give informed consent to its terms during our professional relationship.

_____ _____

Signature of Client Date

I, the undersigned, certify that I have insurance coverage with _____and assign directly to Carolyn M. Bates, Ph.D., all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Dr. Bates to release to my insurance company/managed care company the Protected Health Information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist or Witness Date Form updated: 8/2011

HIPAA Consent Form

Consent to Use and Disclose Health Information

This consent form is required, according to Federal HIPAA regulations, for Dr. Bates to provide services.
I understand that as part of my healthcare, Dr. Carolyn Bates originates and maintains health records describing my health history, symptoms, evaluation, test results, diagnosis and treatment plans. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the health professionals who contribute to my care.
3. A source of information for applying my diagnosis and the services rendered to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand and have been provided with, or have been provided access to, a Notice of Information Practices (NIP) that provides a more complete description of information uses and disclosures. I understand that I have the right to review the NIP prior to signing this consent form. I understand that Dr. Bates reserves the right to change her NIP and prior to implementation will provide access to the new NIP. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Bates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Bates has already taken action in reliance thereon.

Patient Rights
HIPAA provides you with several new or expanded rights with regard to your health record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your health record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Accepted_____ Declined_____

_____ _____
Client Signature Date

_____ _____
Signature of personal representative of client (if applicable) Date

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

Purpose of this Notice

My office respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes further my privacy practices with respect to your health information. My privacy practices apply to current and former patients

Types of Personal and Health Information We Collect

I collect a variety of personal and health information when delivering mental health care. You provide some of this information when you initially come to my office (such as address, Social Security number, and health history). I also may receive additional personal and health information (such as eligibility) through my transaction with employers, insurance companies, and other health care providers. I limit the collection of personal information to that which is necessary to administer my business, provide quality service, and meet regulatory requirements.

How I Protect Personal and Health Information

I treat personal and health information securely and confidentially. I limit access to personal information to only those persons who need to know that information to provide services to clients (for example, my billing or tax administrator). These persons are trained on the importance of safeguarding all confidential and private information and must comply with my procedures and applicable laws. I meet physical, electronic and procedural security standards to protect personal and health information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal and Health Information

I may share any of the personal and health information I collect (as described above) with my associates as permitted by law. I may also disclose this information to non-associated entities or individuals as permitted or required by law. Non-associates with whom I may disclose information as permitted by law include my attorneys, accountants and auditors, a patient's authorized representative, other health care providers, public health authorities, coroners, medical examiners, and funeral directors, organ donation organizations, Institutional Review Boards for research purposes, third party administrators, insurers, and law enforcement or regulatory authorities. I may also disclose any of the personal and health information I collect (as described above) in order to provide appointment reminders or cancellations, or to give you information about other treatments or health-related benefits and services that may be of interest to you. In addition, in the event that this office is sold or merged with another office, your personal and health information will become the property of the new owner. I do not disclose personal or health information to any other third parties without a client's request or authorization, or the request or authorization of a client's personal representative.

Individual Rights to Access & Correct Personal & Health Information

I have procedures for a client to access the personal and health information I collect, other than information I collect in connection with, or in anticipation of, a lawsuit or legal claim. I will make this information available to the patient upon written request.

My goal is to keep patient information up-to-date and to correct inaccurate information. I have procedures in place to ensure the integrity of my information and for the timely correction of incorrect information. If you believe that any personal or health information I have about you is not accurate, please let me know by contacting me.

Amendment of Privacy Practice Notice

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this Notice.

I have reviewed and understand the information cited on this page.

_____ _____

Client Signature Date of Signature

_____ _____

Witness Date of Signature