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 PARTNERSHIP STATUS DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE

/
HOME PHONE CELL PHONE

OCCUPATION SCHOOL EMPLOYER

MEDICATIONS YOU ARE CURRENTLY TAKING

YES NO
PHYSICIAN PHONE (May this person be contacted if needed?)

PERSON TO CONTACT IN CASE OF EMERGENCY PHONE RELATION TO YOU

CURRENT REASON(S) FOR SEEKING PSYCHOTHERAPY

Signature of Client Date

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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 Protected Health Information. You have the right to revoke this permission at any time by communicating your desire to me either in writing or orally.

___ My physician, please identify._____

___ My spouse/partner, please identify._____

___ My family member, please identify_____

___ My attorney, please identify._____

___ My children, please identify_____

___ Other, please identify_____

Form updated: 1/2022

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OFFICE POLICIES AND PSYCHOLOGICAL TREATMENT CONTRACT

Initial Consultation

An initial consultation allows us to talk about your reasons for seeking psychotherapy, and to discuss 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 or 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.

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

D. **Criminal investigations**: If you are involved in a criminal investigation your records may be subject to possession by investigating law enforcement agents.

E. **If you are filing a complaint or are a plaintiff in a lawsuit**: Where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of your records in the context of the 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.

F. **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.

G. **When you sign a release of information of your records**: This directs me to share that information with another party.

H. **Nonpayment for services**: This would require that I give your name to a collection agency to seek payment for any balance due.

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 48 hours' notice of cancellation. *To avoid being charged for missed appointments, you must provide me with at least 48 hours' notice for cancellation.*

Professional Fees and Notice of Good Faith Estimate

To avoid misunderstandings, please understand that responsibility for payment of professional services is yours. My fee is $250.00 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, 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, you will be charged for my professional time. Because of the difficulty of legal involvement, my fee for preparation and attendance at any meeting related to your legal proceeding is $475.00 per hour.

Billing and Payments
I request payment at the time a session is held, unless we agree otherwise or unless you have insurance coverage, which requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a temporary fee adjustment or payment installment plan. 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. I will fill out billing forms and provide you with whatever assistance I can to help you receive the benefits to which you are entitled; 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.

Managed Care Plans
I am not contracted with any managed care plan and do not submit billing paperwork. If you wish to submit your own claims to your insurance company, I will provide you with a receipt for services that includes date of service, service offered, and diagnosis. Most insurance companies require you to authorize me to provide them with a clinical diagnosis. You should be aware that diagnostic information will become part of the insurance company files and will probably be stored on their servers. 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 diagnostic 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.

Medicare Opt Out
Please note that I have permanently opted out of Medicare.

Maintaining Professional Service
In the interest of continued professional development and integrity of treatment, I engage in peer consultation as I see a need to. If I see a need to do so with your case, please know that I will change any and all identifying details to assure that your identity will stay confidential.

Independent Practitioner Status
Although I share this office suite with other mental health clinicians, we are independent practitioners and are not formally affiliated with each other.

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 the burden of financial debt.

Record Keeping
I keep relatively detailed notes of your sessions to allow for consistency of treatment over time. At times clients may wish for their therapists to keep a minimal record in order to provide maximum protection and privacy. Please indicate below if you would prefer that I keep a minimal record.

_____ Yes, please maintain a minimal record of my treatment.
_____ No, please maintain a customary record of my treatment.

Professional Executor
In the case that I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague who is a licensed psychologist as my professional executor. If I die or become incapacitated, my professional executor will be given access to all of my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services if needed; and/or to facilitate continued care with another qualified professional if needed. If you have any questions or concerns about this professional executor arrangement, I will be glad to discuss them with you.

Record Maintenance and Disposition
In accordance with state law, I will maintain your treatment records until 7 years after our final session, after which they will be properly disposed. Should you want either a copy of your records or a summary of your treatment sent to another mental health provider, this would be possible only within that 7-year window.

Postmortem Disclosure of Records
There are times the unexpected happens. In the event that a client passes away before their records are disposed, post-mortem disclosure of records remains a possibility should the holder of privilege, such as the executor of a client's will or their next-of-kin, wishes to have access to the client's records. Many clients prefer this not to take place if they feel that the content of their records could prove harmful to the person or persons who might make such a request. Please indicate below how you would wish me to handle this situation, were this situation to present itself.

_____ Yes, should the overseer(s) of my estate request a copy of my records, please accommodate this request.
_____ Yes, should the overseer(s) of my estate request a copy of my records, please provide only a summary of my treatment.
_____ No, should the overseer(s) of my estate request a copy of my records, please do not accommodate this request. It is my wish that my confidentiality be maintained.

Ending Therapy Sessions
Either the therapist or the client has the right to stop ongoing therapy. Most of the time therapy ends by mutual agreement when the client's goals are sufficiently reached and/or their symptoms have been sufficiently addressed. If I believe that the therapy is either not helping you or is harmful to you, I will speak with you about ending the work and/or transferring your case to another therapist. If you ever feel that the therapy is not helping you, I urge you to speak directly with me about this. If you stop coming in without giving notice of your intention, I will close your file *30 days after our last appointment* and will send you a letter informing you of this. Closing your file means that I am not readily available to assist you during crisis or with ongoing sessions. If you would like to re-enter therapy with me after your file is closed, treatment may restart after meeting to discuss and understand the reasons you stopped and if I have an opening in my schedule.

Emergencies
If you are an active client, 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 national hotline (988), the local mental health hotline (512-472-HELP) which provides around-the-clock telephone crisis counseling and information. **If your situation is life threatening, please call 911, your family physician, 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. With your signature below you agree that you have read the Professional Fees and Notice of Good Faith Estimate and that you agree to pay your psychologist's fees.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist or Witness Date

Form updated: 05/2023

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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 Texas Notice Form (TNF) that provides a more complete description of information uses and disclosures. I understand that I have the right to review the TNF prior to signing this consent form. I understand that Dr. Bates reserves the right to change her TNF and prior to implementation will provide access to the new TNF. 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.

_____ _____
Client Signature Date

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

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

_____
_____
_____
_____

_____ _____
Client Signature Date

Patient Privacy Policy

I consider you a partner in your mental health treatment. When you are well informed, participate in your treatment decisions, and communicate openly with me and any other health professionals involved in your care you help make your care is effective as possible. I encourage respect for the personal preferences and values of each patient with whom I work.

Your Rights as a Patient

You have the right to impartial access to treatment or accommodations that are available or indicated regardless of race, ethnicity, creed, sex, sexual preference, national origin, age, or disability.

You have the right to be informed about your treatment plan and possible outcomes and to discuss them with me.

You have the right to know the names, professional credentials, and the role of the people treating you.

You have the right to privacy, and I will protect your privacy as much as possible. I will obtain authorization before using or disclosing any of your PHI.

You have the right to expect that your psychotherapy records are confidential unless you have given permission to release information or reporting is required and/or permitted by law. When I release records to others, such as insurers, I emphasize that those records are confidential. Our practices are in compliance with all HIPAA requirements.

You have the right to review your psychotherapy records and to have the information explained, except when restricted by law.

You have the right to expect that I will give you the necessary psychotherapy services to the best of my ability. Treatment, referral, or transfer may be requested or recommended, and you will be informed of the risks, benefits, and alternatives should this become relevant.

You have to right to know if I have relationships with outside parties that may influence your treatment and care. These relationships may be educational institutions, other healthcare providers, or insurers.

You have the right to know about our rules of practice and ethical guidelines that affect you and your treatment.

You have the right to be told of realistic care alternatives.

You have the right to know about resources that may help you resolve problems, complaints, and questions about your care.

You have the right to considerate and respectful care.

You have the right to request and receive an itemized statement of your charges regardless of the source of payment.

You have the right to make statements regarding any aspect of your care - in written form or verbally. I encourage and respect your feedback.

You have the right to be placed in a protective environment when it is deemed necessary for your personal safety.

You have the right to participate in all aspects of your psychotherapeutic treatment.

You have the right to receive instructions and/or psycho-education to allow you to achieve an optimal level of wellness and an understanding of your basic needs.

You have the right to access your psychotherapy records. You have the right to challenge the accuracy of these records and to have your records corrected. You also have the right to transfer all such records to another mental health professional in the case of continuing care.

You have the right to receive information regarding your financial responsibilities, charges, payments and payment plans, and insurance requirements.

You have the right to protection of your identity to guard against identity theft. You have a right to be notified if there is a breach in the use or disclosure of your PHI in violation of the HIPAA Privacy Rule, that has not been encrypted to government standards and our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Your Responsibilities as a Patient
You are responsible for completing all necessary forms related to your mental health care and financial responsibilities. If you are unable to comply, please request our assistance.

You are responsible for working with me to arrange payment for services, and for asking questions when you do not understand information regarding your financial responsibilities for payment of services

You are responsible for providing correct and up-to-date information for any insurance claims that I agree to file on your behalf.

You are responsible for providing a photo ID at your
Austin, Texas 78701
intake session.

You are responsible for asking questions when you do not understand information or instructions related to your mental health treatment. If you believe you cannot follow through with your treatment or treatment recommendations, you are responsible for informing me.

Your mental health depends not just on your psychotherapeutic treatment but also, in the long-term, on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal mental health.

Understanding Your Bill
Insurance companies generally require that psychotherapeutic treatment be medically necessary, i.e., that your bill includes documentation of a DSM mental health diagnosis that is descriptive of the concerns you bring to your therapy. Without this diagnosis, insurance will generally not pay for your care. You have the right to appeal decisions made by her insurance. company, and I will assist you in this as I am able.

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

Complaints/Grievances
If you have a complaint regarding your treatment while working with me that has not been resolved to your satisfaction, you may contact the Texas State Board of Examiners of Psychologists' Complaint Hotline at 1-800-821-3205 or write them at:

Texas Behavioral Health Executive Council
1801 Congress Ave., Ste 7.300
Austin, TX 78701