PREMIER
PSYCHIATRIC & SLEEP MEDICINE ASSOCIATES
Healing Minds ★ Restoring Sleep

935 W. Exchange Pkwy, Ste. 110 Allen, TX 75013

PH# 972.985.7499 FAX# 972.985.7429 premierpsychiatric1@gmail.com

Welcome to Eximious Integrated Health Solutions!

We would like to say thank you for considering and choosing us as your trusted provider for care and well being.

It is vital in a Provider/Patient relationship that you are absolutely upfront and forthcoming with all relevant information that pertains to your psychiatric health. Our goal is to obtain and maintain this wellbeing in coordination with **you** as our patient.

This will require YOU to :

- Follow all recommendations regarding medications, treatment plans and measures for safety and protection.
- Be responsible for keeping medications in a SAFE place and ensure that all medications are taken ONLY as prescribed by your practitioner.
- Inform us of any changes to insurance, personal contact information, medical treatment and/or changes that affect treatment with us-

  including Intensive Outpatient Treatment and Partial Hospitalization programs,

  Treatment Centers regarding addiction(s) and regular hospitalization ie, surgery.

Termination of Provider/Patient Relationship:

The following are situations that would cause us to sever this relationship:

- Continued missed / cancelled appointments
- Non payment of account
- Non compliance as a patient/not following recommended course of treatment
- Misuse/abuse of prescribed medications/ obtaining same medications from other prescribers, primarily controlled substances
- Abusive or inappropriate behavior towards clinic staff and practitioners

You will receive a certified letter stating the severing of our relationship should the need arise.

We reserve the right to invoke this option at any time. We will fill all non controlled substances for 30 days following the date of the letter.

Patient Signature : _____ Date: _____

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Questionnaire for New Patients:

Name: _____ Date of Birth: __/__/__ Age: _____ Sex : _____

Phone Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Referred by: _____ Phone Number: _____

Please state your view of your challenges/symptoms/reason for the visit:

_____

_____

_____

When did the problems begin: _____

What has been done so far to help alleviate the issue(s):

_____

_____

_____

Psychiatric History:

Has you ever been hospitalized for psychiatric care/needs? YES ☐ NO ☐

If so, Where and When: _____

Reason for Hospitalization: _____

Was treatment helpful/successful: _____

Have you had any other prior psychiatric providers, ie outpatient psychiatric medication management, behavioral counseling or therapy? YES ☐ NO ☐

If yes, please list provider: _____

_____

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Date: _____

Patient Name: _____ DOB: _____

Social Security # _____ Sex: Male ☐ Female ☐ Other ☐

Ethnicity : ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown

Race : ☐ American Indian ☐ Asian ☐ Black / African American ☐ White ☐ Native Hawaiian ☐ Other

Address: _____

City: _____ State: _____ Zip: _____

Home phone # _____ Cell # _____ Work # _____

Marital Status: _____ Email: _____

Employer _____

In Case of an Emergency, who can we contact?

Name: _____ Phone # _____

Relationship: _____ Cell # _____

Can we release ALL personal health information to the following? (Please provide names)

School Nurse / School Counselors: _____ PCP: _____

Employer / HR Department: _____ Counselor / Therapist: _____

Social Security Department _____ Doctor: _____

Texas Dept. of Family and Protective Services-CPS Other: _____

Attorney Office: If yes, please provide Attorney's name & phone # _____

Insurance Information:

Insurance company: _____ Member ID/ Policy # _____

Group # _____ Insurance phone # _____ Employer: _____

Name of Primary Policy Holder: _____ Primary Holder's DOB: _____

Primary Holder's SSN: _____ Relationship to Patient: _____

Is Primary Policy Holder the Responsible Party? ☐ Yes ☐ No (Adult patients are responsible for their own financials)

If No, Responsible Party / Guarantor's Information:

Responsible Party Name: _____ Home/Cell Phone # _____

Address _____

City: _____ State: _____ Zip: _____

Patient/Guardian Signature: _____ Date: _____

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Patient Health Questionnaire-9

(PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half of the days	Nearly daily
Please circle or mark the number or category of your answer:	0	1	2	3
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-feelings of failure and letting others	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper,	0	1	2	3
8. Moving or speaking so slowly that other people have noticed? Or the opposite-so fidgety and restless, moving around a lot more than	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in	0	1	2	3

For office coding: _____ + _____ + _____ + _____

Total = _____

If you checked off ANY problems, how DIFFICULT have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all ☐ somewhat difficult ☐ very difficult ☐ extremely difficult ☐

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General Office Policies and Procedures

Financial Agreements

Appointments

It is the responsibility of the patient to schedule, reschedule, and cancel all appointments with our office.

Due to limited appointment availability we have implemented a No-Show policy. There is a $75.00 fee.

There will also be a $50.00 fee applied to all appointments that have been cancelled late, within 24 hours.

We require a minimum of a 24 hour notice for any appointment cancellation. Emergencies do arise and we appreciate notice if you are unable to make your scheduled time. Please contact us as soon as possible.

Eximious Integrated Health Solutions/Premier Psychiatric will make every effort to contact our patients 2 business days before their appointment, this is a courtesy and it is the patient's responsibility to keep your appointment on your scheduled date. Should the clinic require the rescheduling of your appointment, we will contact you as soon as is possible to notify you of any changes due to unforeseen circumstances. Please be certain all contact numbers and email addresses are up to date.

Any patient arriving **15 minutes or later** for their scheduled appointment time will be rescheduled
NO EXCEPTIONS– When you are late, it causes other appointments to be late as well.

Repeated "no show" or "late cancelled" will result in being referred out of the practice to another practitioner.

We do not do phone appointments. In the case of an emergency, where you cannot make it into the clinic for your visit, there will be a fee of $150.00 for the phone appointment and that fee will be due in advance of your phone call. We cannot bill your insurance for this phone appointment, **it is your responsibility**.

Prescriptions and Samples

It is the responsibility of the patient to take or mail their prescriptions to their chosen pharmacy.

There are NO early refills

Mandatory urine toxicology screenings will be done on all patients that receive controlled substances or on Suboxone Therapy. You will NOT be seen or given a prescription for your medication without a urine sample and you will be subject for termination from our practice. If you are taking any type of Controlled Substances and you test positive for any type of pain medication you will be referred to your PCP or Pain Specialist to be tapered off of these medications. You will not get a prescription if you are taking pain medications along with your controlled medications. By doing so, you will receive only one warning and if caught again, you will be subject to being terminated from our practice.

If refills are needed for an emergency purpose, please contact your pharmacy and ask them to fax a refill request to our office. We require at least a 48 hour notice.

If you are unable to keep your scheduled appointment please be informed that you will not receive refills until you have been seen by your provider.

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Medical Records and Forms

There is a $150.00 administrative fee for completing and filing all elective medical documentation; this includes all FMLA paperwork and Short Term/Long Term Disability Paperwork.

Please see our policy for this process once you are an established patient with the clinic. It is posted in the front

Please allow up to 7 days for the completion of your document. We will contact you once they are completed.

All requested letters for any reason will be charged a fee of $25.00 up to $150.00 depending on the need. Letters will need to be picked up in the office and must be paid for before we will release it to you.

Payment and Fees

Payment is due at the time of service rendered with no exceptions. This includes co-payments, co-insurance, and yearly deductible.

Past due balances and payment arrangements may be made with the office manager only.

We accept cash and credit card payments. We no longer accept personal checks.

Court Fees:

If a deposition or opinion in court is required, there is a $2000.00 fee that will be due upon the receipt of a subpoena and a fee of $450.00 per hour for our Nurse Practitioner , and $600.00 per hour fee for our MD to go to court, per day they are in court. If the Medical Assistant is subpoenaed to appear on your behalf, there will be a $500.00 fee due upon receipt of the subpoena. There will also be a $500.00 fee, per day that the medical assistant is due to be at the court. All court fees will be due no later than 10 business days after the court has been adjourned. All fees are your responsibility and will not be billed to your insurance. These fees are being charged for preparation time, travel time, any time spent with your attorney / clerk for preparation and cancelling of our staff's clinic schedule.

All fees including late cancellation and no show fees are not final, and are subject to change at any time without notice based on the discretion of the practice.

I have read, understood, and agreed to the policies listed above for :

Premier Psychiatric and Sleep Medicine Associates, Eximious Integrated Health Solutions. I accept the conditions for receiving services from Dr. Jawad Riaz, MD, Dr. Sabeen Riaz M.D., the Nurse Practitioners and/or the counselors/therapists.

_____ _____

Patient Signature Date

_____

Patient Printed Name

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NOTICE OF PRIVACY PRACTICES

11/29/2018

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.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This notice describes our Practice's policies, which extend to:

Any health care professional authorized to enter information into your chart; all areas of the Practice; all employees, staff and other personnel that work for or with our Practice; our business associates, on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We will make sure that the protected health information about you is kept private;

provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and

follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

We use and disclose health information about you for treatment, payment and healthcare operations. For Example:

Medical Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment and Patient Recall Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise which could (potentially) be received or intercepted by others.

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To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

Public Health Risks: Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities: We may disclose medical information to a local, state or federal agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order or a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process about a victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at the Practice; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner, medical examiner or funeral director.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

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CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. Each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager (903.892.6700), who will direct you on how to file an office complaint. All complaints must be submitted in writing, and shall be investigated, without repercussion to you. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization, unless those uses can be reasonably inferred from the intended uses above. You may revoke that authorization in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission.

PATIENT RIGHTS

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include **psychotherapy notes**. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. We may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request. We may deny your request to inspect and copy in limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. We will comply with the outcome and recommendations from that review.

Right to Amend: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Right to A Paper Copy of this Notice: You have a right to a paper copy of this notice at any time upon your request.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's

Notice of Privacy Practices. _____ _____

(Signature) (Date)

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please list individuals who may receive and use the disclosed information:

_____

_____

_____

_____

☐ **All Information**

☐ **Appointment information**

☐ **Lab Work**

☐ **Financial Information**

☐ **Medical Records**

☐ **Personal Identifying Information**

☐ **Insurance Information**

Other (Specify) : _____

_____ _____

Patient Signature **Date**

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Welcome

Welcome to our practice and thank you for choosing to work with us. The role of a therapist is to help you recognize your needs and wants, and to offer you support during the process of healing and growth. Our therapeutic philosophy is a strength-based approach that is based on our belief that you are the expert of your life. We will work together to discover the best way for you to find answers to your problems. We look forward to our work together.

Credentials and Services

Our LPC's provide services to individuals, couples and families. Both have met all of the requirements set by the Texas State Board of Health for Licensed Professional Counselors (LPC).

Thomas Files, LPC holds a Masters of Arts from Amberton University.

Jeffrey Ross, LPC holds a Masters in Behavioral Studies from Southeastern Oklahoma State University.

Office Policies and Procedures

Please read and review carefully all the following information signing where it is indicated. These informational documents outline your rights of confidentiality as a client and the therapist/counselor's role and responsibility to you. You will be provided with a copy of all signed documents at your request. Individuals who have seen a therapist in the past may find forms that are not familiar. We have made it best practice to include HIPAA compliance agreements as well as consents for release with your counseling paperwork.

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Confidentiality and Informed Consent

The therapeutic relationship requires complete confidentiality between client and therapist. Information about clients, including case notes and records are confidential and are the property of Thomas Files, LPC or Jeffrey Ross, LPC.

The Texas Health and Safety Code have established the following limits of confidentiality.

You should be aware of these **exceptions to confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.

2. You are at risk of imminent serious harm to yourself or others*;

3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;

4. You disclose sexual misconduct of a physician or therapist;

5. Information is requested by your insurance company pertinent to processing claims for payment;

6. A court order is received to disclose information (e.g. child custody or mental competency cases);

7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

By signing below, you are stating that you have read and understood the rules of confidentiality.

_____ ___/___/___

Signature of Client Date

_____

Printed Patient Name

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Patient Privacy Notice (HIPAA)

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures
We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.
To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

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In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Please answer yes or no and circle your wishes stating that you understand that, and consent to the following appointment reminders that may be used by the Provider:

_____ **Yes** _____ **No** You **may/may not** leave a message with anyone who answers my home phone.

_____ **Yes** _____ **No** You **may/may not** leave a message with anyone who answers my home phone but do not divulge the message is regarding counseling.

_____ **Yes** _____ **No** You **may/may not** only leave a message with:_____

_____ **Yes** _____ **No** You **may/may not** leave a message on my work voicemail.

_____ **Yes** _____ **No** You **may/may** not leave a message with someone answering my work phone but do not divulge the message regards counseling.

_____ **Yes** _____ **No** You **may/may not** contact me by email at my personal email account

_____ **Yes** _____ **No** You **may/may not** contact me by email at my business email account

_____ **Yes** _____ **No** You **may/may not** contact me and leave a message on my cell phone.

_____ **Yes** _____ **No** You **may/may not** send text messages to me.

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Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____ _____
Name of Individual (Printed) Date

_____ _____
Signature of Individual

_____ _____
Signature of Legal Representative Relationship to Client
(E.g., Attorney-in-fact, Guardian, Parent if minor)

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Fee Agreement and Payment

We as a practice accept cash, credit cards, and BCBS, Cigna, Aetna and United Healthcare insurance. Not all plans / tiers are covered. It is the responsibility of the patient to "know your benefits". If you are unaware of what your co-pays or deductibles may be, please personally contact your insurance companies. What balance is not paid by your insurance company will be billed to the patient. Payment is required at the time of service. If there is a point you show up for your scheduled appointment and there is not a staff member at the front desk, it is your responsibility to call the office back on the next business day and pay your co-pay, co-ins, or deductible.

Cash Fee Agreement

Sessions are $125 per 50-minute session for new patients and $100.00 for a 40 minute session for returning patients. Longer sessions are available on a case-by-case basis and will be billed based on the amount of time in session. Prices and fees are subject to change at anytime, without notice.

Other Payment Options

We are committed to working with you and we have placed a fair market value on the services I provide. However, we do not want an insurance company's allowed sessions (maximum visits reached), a job loss, or other crisis to impede the therapeutic process. Consequently we offer a sliding fee that is available to our clients based on need and circumstances. The sliding scale ranges from $65.00-$80.00 per 40-minute session and will be negotiated between client and therapist.

Court Action Policy and Fees

Clients are discouraged from having either Thomas Files, LPC or Jeffrey Ross, LPC subpoenaed or having him provide records for the purpose of litigation. I am trained as a therapist and my work and therapeutic philosophy comes from non-adversarial position. I have not been trained forensically or with the expertise to appear in court.

We are unable to guarantee that any testimony that we are required by law to give will be solely in your favor. We can only testify to the facts of the case and professional opinion.

If Thomas Files, LPC or Jeffrey Ross, LPC is to receive a subpoena then the attorney or office staff will need to call my office and set up a time for the subpoena to be served during office hours. We request a minimum of 72 hours notice of any Court appearance so that schedule changes for my clients can be made within a reasonable time frame.
Please note: if a subpoena is received without a minimum of 72 hour notice there will be an additional $250 express charge.

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Court action fees are as follows:

1. Preparation Time: $125 per hour
(Billable in 15-minute increments)

2. Phone Calls: $125 per hour
(Billable in 15-minute increments)

3. Filing Document with court $100

4. Minimum charge for court appearance $1,000.00 for half day
$2,500 for full day

5. Attorney fees: I agree to pay all attorney's fees and costs that are incurred by Thomas Files as a result of any court action.

6. Retainer: A retainer of $1,000.00 is due at least 72 hours before the scheduled appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt.

If a therapist is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given then the client will be billed $1,000.

Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

_____ _____

(Client Signature and Date)

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Other Important Information About The Practice
Office Hours

Office hours vary throughout the week. If you are in need of an appointment please contact the office at 972.985.7499 to request and appointment date and time.

Appointments

We will make every effort to make appointments that are convenient for you. Appointments are made on the hour and are 40-50 minutes in duration. The frequency of appointments will be discussed at the first session.

Therapist/Client Communication
Charges will be made for client initiated telephone calls that exceed fifteen minutes, as well as letters, or reports requested by you. The rate for phone calls, letters or reports will be prorated depending on the length of the call or preparation time. We do not conduct therapy via electronic means (i.e. email or text). I believe that your confidentiality is violated in the process and emails and text are subject to subpoena if part of your file.

Cancellation Policy:

If you find it necessary to cancel an appointment during normal business hours, please call the office at (972) 985-7499. You may leave a message at any time day or night, weekends or holidays.

You will be charged for appointments missed without 24-hour notice of cancellation unless it is an extreme emergency. Our Cancellation/No Show fee is $75.

Emergency Calls
You may reach the practice at the normal phone number during the weekend.

If there is an extreme life threatening emergency you will need to call 911 or go to the emergency room of the nearest hospital.
The following numbers may also be helpful:
- **_Crisis Hotline: 972 233-2233**
- **_Suicide Hotline: 214-282-1000**

Responsibility for Treatment

As with any other procedure, psychotherapy involves some risks. Whenever you make significant changes in your lifestyle, outlook or habits, your life and the lives of those with whom you are closely involved will be affected. While the purpose of psychotherapy is to makes make changes, you will want to consider the consequences that might arise. Whatever changes you make will be both your choice and your responsibility. If you become concerned about the course of your therapy, please let me know so that you can have the course of treatment best for you.

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Ending Therapy
The end of therapy is an important process. It is a time to review, to recognize progress, to note areas in which you want to continue growth. It is also a time to receive feedback and encouragement. When you are ready to discontinue therapy, please discuss this at the beginning of your appointment in order to have therapeutic closure.

Complaints and Grievances:

I make every effort to provide services that are pleasing to you. If you believe I have failed to provide satisfactory care or have acted unprofessionally or unethically, please let me know, so I am able to correct this. To file a grievance with my licensing boards, you may write to:

Texas State Board of Examiners of Professional Counselors
1100 W. 49th St.
Austin, Texas 78756.

Agreement

I have read the above and accept the foregoing policies. A copy of this form is valid as the original. I certify that I am an adult over sixteen years of age and consent to the above conditions for therapy.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date
(Parent, guardian, legal representative)