GRAHAM PSYCHOLOGICAL ASSOCIATES

Client Name (Last) _____ (First) _____ (Middle) _____Client date of birth_____

Client Address_____ City/State_____ Zip_____

Client Home Ph _____ Client Work Ph _____ Client Cell Ph_____

E-Mail address:_____ May we send your invoice by e-mail ___yes ___no

Can we leave messages at home? ___ work?___ cell?_____ Preferred Method of contact: Phone_____ E-mail_____

Client SS#_____ Education _____ Client Physician_____

Current Medications_____(type/amt)

Previous counseling/psychotherapy ____Yes ___No If yes, list counselor and dates_____

Who referred you to our office?_____ May we thank them for the referral? ____Yes ___No

Please check the following three statements:

1. Client Relationship to Insured: ___Self ____Spouse ____Child ____Other
2. Client Status: ___Single ____Married ____Other
3. Client Status: ___Employed ____Full Time Student ___Part Time Student

If billing insurance, please complete the following (subscriber information): (If worker's comp: Date of Injury: _____)

Insured's ID Number_____ Insured's Name (if different from client) Last_____ First_____

Insured's date of birth_____ Insured's Group Policy Number_____

Insured's Address_____City/State_____Zip_____

Employer's Name or School Name_____ Insurance Plan Name or Program Name_____

Customer Service Phone Number for Benefits, Eligibility, and Precertification_____

_____ City/State_____Zip_____

Responsible Party (if client is a minor):

Name_____ Relationship_____ Date of birth_____

Address_____City/State_____Zip_____

Home Phone _____ Work Phone _____ Emergency Contact Number _____

Can we leave messages at home?_____ or work?_____

I give this office permission to release any information obtained during treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to the practitioner (Bryan Ray, LPC, Andra Ray, LPC, Dr. Brandon Bates, Dr. Kerri Bates, and/or Dr. Barbara Hill) all rights, title and interest in the benefits payable for services rendered by practitioner, provided in the above mentioned policy of insurance. Said irrevocable assignment and transfer should be for the recovery on said policy of insurance, but shall not be construed to be an obligation of practitioner to pursue and such right of recovery provided. However, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier. I hereby authorize the insurance company herein listed above to pay directly to practitioner all benefits due under said policy by reason of services rendered therein. I will pay practitioner for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy.

A copy of the authorization shall be considered as effective and valid as the original. Signature below indicates agreement to all of the statements on this form.

_____ _____ _____

Client (or responsible party's) signature Printed Name Date

GRAHAM PSYCHOLOGICAL

ASSOCIATES

Informed Consent

Below are listed some important facts regarding your treatment at Graham Psychological Associates. Please read them carefully. If you have any questions, please raise them with your therapist.

Services Provided: Graham Psychological Associates provides psychological services including diagnostic assessment and treatment planning, psychological testing, consultations, individual/ family, and group psychotherapy. Your therapist will discuss with you the treatment choices best suited for your needs. The extent and duration of your evaluation/treatment will depend upon your choice and the recommendation of your therapist/evaluator.

Payment of Fees: Payment is expected at the time of service, if your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment covered by insurance become due and payable sixty (60) days after the date of service. This period allows sufficient time to process insurance and makes payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within 60 days, Graham Psychological Associates will begin various collection activities.

Children of Divorced Parents: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Graham Psychological Associates.

Court Appearances: If for whatever reason we are required to appear at a court hearing on your behalf the fee will be **$200.00** per hour payable by you. Minimum of 4 hours charged. Insurances do not cover court appearances and you will be responsible for fees resulting in a court appearance. This will cover travel time, appearance time, any preparation time, etc.

Cancellation/Late Policy: If you need to cancel an appointment, please notify this office as soon as possible. After 3 no-shows the case will be administratively closed. The fee for late cancellations **(without 24 hours notice)** or broken appointments is **$50.00**. If you are 15 mins. or more late you will be charged a no show fee and rescheduled. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Confidentiality: Within this practice, the therapist group will consult cases on an as need basis, with all therapists abiding by the confidentiality agreement addressed in this section. All information and records will be kept confidential, and will be held in accordance with state laws regarding the confidentiality of such records and information. In most situations, information about treatment can only be released to others if a written Authorization form is signed. . However, records and/or information will be released **regardless of consent** under the following circumstances:

1) According to state and local laws, therapists must report all cases of physical or sexual abuse or neglect of minors or the elderly to the appropriate agency;

2) According to state and local laws, therapists must report all cases in which there exists a danger to self or others to the appropriate agency;
3) When authorized by the recipient of services in order to process medical insurance claims and to authorize payment of benefits;
4) In the event that a patient is in need of emergency services and other medical personnel need to be contacted;
5) In the even that your records may be subpoenaed by court;
6) Disclosures required by health insurers or to collect overdue fees;
7) If care is related to a worker's compensation claim, upon appropriate request, records will be provided relating to treatment or hospitalization for which compensation is being sought;
8) If an individual or organization files a complaint or lawsuit against a clinician at Graham Psychological Services, relevant information regarding such will be disclosed in order to appropriately defend actions.

Right of Access to Records: Adult patients, and legal guardians of minors, including managing and possessory conservators, have the right to access the record of the services provided to them at Graham Psychological Associates. Please discuss any questions you have about this with your therapist/evaluator.

Emergency/On call Services: If you have an emergency, please contact your nearest hospital Emergency Room or call 911. Office hours are by appointment only. By signing this consent form, the client or guardian recognizes this and still wants to continue outpatient therapy at Graham Psychological Associates.

Treatment of Minors: Treatment of children under 18 will be provided only with the consent of the legal guardian. By signing this consent form, the person acknowledges that he or she is the legal guardian (as established by the State or by divorce decree) of any minor presented for treatment and is at least 18 years old him or her self. Exceptions to this include if treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse. If this is the case, parents may not access their child's records.

Receipt of Privacy Practices:
I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of Graham Psychological Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Graham Psychological Associates at (940) 549-2259 or in writing at 617 Third Street, Graham, Texas 76450.

I have read and understand this statement of informed consent. I consent to treatment with clinicians of Graham Psychological Associates with knowledge of the above conditions.

Client/Guardian Signature _____ Date _____

Witness Signature _____ Date (rev. 4/10/13)