1502 N. 1st Street; Abilene, TX 79601
325.672.9999 ❖ 800.375.8793 ❖ 325.672.5237 (fax)

Client Services Agreement/Informed Consent Form

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we offer you a copy of Notice of Privacy Practices (the Notice). The Notice explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. **Although these documents are long and sometimes complex, it is very important that you read them carefully before the first session**. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PROFESSIONAL DISCLOSURE STATEMENT

Overview: The Ministry of Counseling & Enrichment (MOCE) is a professional Christian counseling center. Each of our therapists has varied educational backgrounds and professional experience. Each therapist also has varied Christian denominational backgrounds and experiences. As well, each therapist has a different professional practice regarding the way in which faith-based and clinical principles are integrated. The one thing all therapists have in common here at the MOCE is a desire to be used by a loving God. At the MOCE we believe strongly in the importance of psychological, emotional, relational, spiritual, and physical health. The MOCE also greatly values each client's autonomy. So we encourage you as a client if you have any concerns or questions, to ask your therapist about their professional and personal approach to Christian Counseling.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and outside the clinical setting (e.g. home, school, work).

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Obviously we feel strongly that psychotherapy has stronger benefits than risks. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your own opinions whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

General Information

We normally conduct an evaluation that will last from 2-4 sessions. During this time, you and your therapist can decide if they are the right person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, then sessions are up to 60 minutes in length and occur on a varied frequency (e.g. weekly, 2x monthly, monthly) depending on need. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless client/clinician agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions**.

Inclement Weather Policy

In the event of snowy or icy weather, MOCE will **follow AISD guidelines** for closing the office. If school starts at 10:00 AM then we will open at 10:00 AM, if school is closed, then MOCE will be closed. Therefore, if your appointment is scheduled prior to 10:00 AM, your session will require rescheduling. After school hours or during holidays every attempt will be made to change the answering service message to reflect if the center is open during inclement weather. **We recommend you attempt to call before leaving for your appointment**. We will try to find another time to reschedule the appointment as soon as times are available.

Child Supervision

Children under the age of 15 are required to have a responsible adult on the premises at all times. Children under the age of 8 should be directly supervised in the waiting area by a responsible adult when the therapist is meeting with a parent.

PROFESSIONAL FEES

MOCE hourly fee is $95 for therapists and $150 for psychologist. However, we will take into account your current financial situation and offer you a fee adjustment. Please discuss your financial situation with your therapist. Payment is requested at the time services are rendered. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. **Court appearances: SEE *"Court Fee Agreement Sheet"* included in the intake package**.

CONTACTING YOUR MENTAL HEALTH PROFESSIONAL

Due to our work schedule, we are often not immediately available by telephone. Each therapist has different schedules and many have full time positions at other places of employment. When they are unavailable a phone message will be left for them to contact you as soon as possible. They will make every effort to return your call on the same day you make it, with exception of weekends and holidays. If you are difficult to reach, please include in your message, times and days that you will likely be available. If you are unable to reach your therapist and feel that you can't wait for them to return your call, contact your family physician or the nearest emergency room.

Use of email

Communicating with clinicians directly through text messaging or unencrypted emailing is not recommended due to the insecure nature of the mediums and therefore does not meet the highest standards of confidentiality. On rare occasions, clients may want to provide information to the clinician via email but it is the policy of the MOCE that therapists provide only a response that simply acknowledges the receipt of the message without including any PHI.

Social Media
It is in compliance with state licensing standards and in the interest of maintaining client confidentiality that therapists do not accept "friend requests" or "follow requests" of clients in social media outlets unless it has been over 2 years since treatment has ended. If a client happens to be the "friend" or "follower" of the therapist prior to the beginning of treatment, this status does not need to change, but may be discussed between therapist and client.

LIMITS OF CONFIDENTIALITY
The law protects the privacy of all communications between a patient and a mental health professional. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your clinical record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the clinician-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization **or a court order**. If you are involved in contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against his/her clinician, that clinicians may disclose relevant information regarding that patient in order to defend themselves.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, 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, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that we make a report to the appropriate governmental agency, usually the Department of Family Protective Services. Once such report is filed, we may be required to provide additional information.

- If we determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon himself/herself, or others, we may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. However, in cases that involve child abuse, Section 611 of the Texas Health and Safety laws allows for clinicians to refuse to disclose information to a parent who may pose substantial harm to a child either physically or emotionally.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your psychologist/therapist. The laws governing confidentiality can be quite complex, and the clinicians at MOCE are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPPA, MOCE clinicians keep PHI about you in professional progress records which are collectively referred to as your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your MOCE clinician, or have them forwarded to another mental health professional so you can discuss the contents. Clinicians are sometimes willing to conduct this review meeting without charge. In most circumstances, MOCE is allowed to charge a copying fee of $1.00 per page to cover supply and administrative costs. If your request for access to your Clinical Record is refused, you have a right of review, which your clinician or the MOCE Privacy Officer will discuss with you upon your request.

Clinical records are kept electronically via a secure and encrypted online service. If you have any question about the protection of your records please feel free to ask your therapist or the MOCE Privacy Officer, Steve Queen.

Minors & Parents

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, this can lead to a potential problem in therapy. The clinician must work very diligently to maintain a balance between a teenagers' felt need for privacy/confidentiality and a parent's right to access their child's records. All therapists will work prudently with their clients to find that balance for the good of the teenager, unless it is determined that the client is in danger or is a danger to someone else, in which case, we will notify the parents immediately of our concern.

BILLING & PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

You will not be seen by your therapist when your account is in arrears three sessions, unless some <u>prior arrangement</u> has been made between yourself and the therapist.

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. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, MOCE will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMO's and PPO's often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow clinicians to provide services to you one your benefits end. If this is the case, arrangements can be sought between client and clinician to continue therapy.

You should also be aware that your contract with your health insurance company requires that your therapist provide it with information relevant to the services that MOCE provides to you. Clinicians are required to provide a clinical diagnosis. Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about the client that is necessary for the purpose requested. 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, MOCE and your clinician has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. MOCE will provide you with a copy of any report submitted on your behalf if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once MOCE has all the information about your insurance coverage, your therapist will discuss what can be expected to be accomplished with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE ABOVE AGREEMENT AND AGREE TO ITS TERMS AND GIVE CONSENT FOR THERAPY. THIS ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED THE HIPPA NPP FORM DESCRIBED ABOVE.

_____ _____

Client Signature Date

IF CLIENT IS A MINOR CHILD, THEN AS A PARENT, LEGAL GUARDIAN, OR MANAGING CONSERVATOR OF THIS MINOR CHILD, I DO HEREBY AUTHORIZE THE MINISTRY OF COUNSELING AND ENRICHMENT TO PROVIDE THERAPEUTIC SERVICES AND AGREE TO THE TERMS OF THIS FORM TO MY CHILD.

_____ _____

Parent or Guardian Signature Date

Assignment of Benefits/Insurance Release Form

Client Name: _____ Date of Birth: _____

If you do not wish to have Ministry of Counseling & Enrichment bill your insurance, or you (and/or your minor child) is not insured, check one of the following, sign the document, and skip the insurance information below.

_____ Client is not covered under any health insurance plan.
_____ Client has insurance but does not wish services to be billed to them.

CHECKING ABOVE CONSTITUTES FULL FEE FOR SERVICES

Insurance Company Information

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City: _____ State: _____ Zip: _____

POLICY HOLDER
First Name: _____ MI: _____ ID #: _____
Last Name: _____ Policy #: _____
Address: _____ Group #: _____
_____
City: _____ ST: _____ Zip: _____
Home PH: _____ Work PH: _____
DOB: ____ / ____ / ____ ____ Male ____ Female

Status (TRICARE claims): ____ Active Duty ____ Retired ____ Deceased ____ Other
What is your relationship to the insured? ____ Spouse ____ Child ____ Self ____ Other
Are you under your employer's Health Plan? ____ Yes ____ No
Employer's Name: _____
Insurance Plan Name: _____
Is your signature on file? ____ Yes ____ No
(*If there is another Health Benefit Plan, Please fill out another Insurance Form and write "Secondary Insurer" on the top of the form*)

Financial Responsibility
I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the Ministry of Counseling & Enrichment - MOCE (a.k.a. First Baptist Mission Action, Inc.) for any charges not covered by health care benefits. It is my responsibility to notify MOCE of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by MOCE and/or my insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment of services and or treatment provided.

Assignment of Benefits
I authorize direct remittance of payment of all insurance benefits, including Medicaid and Medicare, to First Baptist Mission Action, Inc. (FBMA) for all covered services provided to me during all courses of treatment and care provided. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by the Ministry of Counseling & Enrichment (MOCE), and will constitute a continuing authorization of any policy that is in effect at the time of service, maintained on file with MOCE, which will authorize and allow for direct payment to FBMA of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, and care provided. This serves as a lifetime consent for Medicare. I authorize MOCE to release information from the medical records of the above mentioned client for the purpose of accessing insurance benefits. This information may include diagnoses, date, and type of treatment received. Additional information may be requested before claim payment is made and may include but not limited to, intake report, treatment plan, progress notes, medications prescribed, and discharge report.

Signature of Client: _____ Date: _____ DOB: _____

Signature of Parent/Guardian: _____

Court Fee Agreement Sheet

***** THIS FORM MUST BE COMPLETED FULLY BY ALL CLIENTS EVEN IF YOU DO NOT FORSEE COURT AS A POSSIBILITY IN YOUR SITUATION.*****

By signing this sheet the client acknowledges that they understand the following expectations and itemized fees:

INITIAL EACH

_____ The fees for court preparation and appearance are set regardless of insurance co-pay or adjusted fee.

_____ Ministry of Counseling & Enrichment clinicians (therapist & psychologist) are Mental Health Professionals (MHP) and cannot testify in court without being subpoenaed per center policy.

_____ The expectation is the initial fee will be paid in full at least 24 hours before mandated court appearance.

_____ If the time at court is longer than the initial expected time then compensation for that time will be expected in a timely manner.

_____ The client whose attorney subpoenas the MHP will be expected to pay the fees unless the court orders otherwise.

_____ Court appearances will require blocking off either a half day or full day depending on the attorney's expectations and need.

_____ The MHP can adjust that amount if it takes less time and they are still able to see other clients in those previously blocked off time slots.

Itemized Fees

Hourly Rate	
● Master's level MHP-	$95.00 per hour
● Doctoral level MHP-	$150.00 per hour
Prep and Record Review Time	
● Up to 3 hours	At above hourly rate
Court Appearances	
● ½ Day	At above hourly rate
● Full Day	At above hourly rate
Travel Cost if Court is out of Abilene	
● Mileage Reimbursement	At Current Federal Reimbursement Rate

_____ _____

Client Signature Date

Credit/Debit Card Authorization Form — Mental Health Services

Ministry of Counseling & Enrichment. * 1502 N 1st Street * Abilene, TX 79601

Please complete the following information:

I, _____ **(print name as it appears on the credit card)** authorize First Baptist Mission Action, Inc. to charge my credit card for charges incurred by _____ **(print name of client receiving services)**. I understand that per clinic policy, my credit card will be charged in the event of a failure to keep a scheduled appointment with less than 24 business hours notification as agreed to in the Informed Consent. Furthermore, for any outstanding payments of services rendered, I authorize First Baptist Mission Action, Inc. to charge my card for the full amount due.

I will not dispute charges for sessions that have been received or that have not been cancelled within 24 business hours in advance. I further authorize First Baptist Mission Action, Inc. to disclose information about my attendance or cancellation to my credit card company if I dispute a charge.

I understand that there will be a $25 fee for any declined credit card charge.

By signing, I acknowledge that this form serves as prior notice of charges and that I have read, understood, and agreed to the terms above:

Signature: _____ **Date:_____**

Card Type: (circle one) Visa MasterCard Discover American Express

Full Name on Card:_____

Card #: _____ Expiration Date:_____

3 digit Verification Code:_____

Billing Address for Card:_____
(Street, City, State, and Zip Code)

Signature of Card Holder:_____

This form is considered protected health information and will be securely stored in your clinical file. The information may be updated upon request at any time. Please note, your credit card will be charged at time of service, whether on line or in person. It will also be charged if there is a no show or if cancellation is less than 24 hours, per agreed upon policy in the informed consent. If you are experiencing financial hardship it is your responsibility to inform the Counseling staff that you are unable to make your payment.***

Ministry of Counseling and Enrichment

GOOD FAITH ESTIMATE

Provider:	TX LPC#
1502 N. 1st Abilene TX, 79601	
Provider Phone #: (325) 672-9999	
Provider Tax ID# 75-1295177	Provider NPI #

Patient Name:	Patient Date of Birth:
Patient Address	
Patient Diagnosis	
Services Requested:	Date of Initial Session (if applicable):

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

The fee for a 50-minute psychotherapy visit (in person or via telehealth) is $_____. Most clients will attend one psychotherapy visit per week or once every other week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

Number of Weeks	Total estimated charges Master Level therapist for 1 session per week $95	Total estimated charges for Doctoral Clinician 1session per week $150
1 Week of Service	$95	$150
13 Weeks of Service (Approx. 3 Months)	$1,235	$1950
26 Weeks of Service (Approx. 6 months)	$2,470	$3,900
39 Weeks of Service (Approx. 9 months)	$3,705	$5,850
52 Weeks of Service (Approx. 12 Months)	$4,940	$7,800

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate _____

_____ _____

Patient Signature Provider Signature