Jaime Theiss, LMFT
3128 Hudson Crossing Bldg E Suite 1
McKinney, TX 75072
469-252-7090

Assignment of Benefits & Consent for Treatment

CONSENT FOR TREATMENT I have been informed about the services in which I and/or my child (ren) will participate with Jaime Theiss, LMFT including length of treatment, confidentiality and exceptions to confidentiality, and nature of the treatment or other procedures. These services may include individual, group or family psychotherapy or counseling, traditional counseling and psychological testing. I am giving consent to my voluntary participation in therapeutic groups run by a counselor from Jaime Theiss, LMFT of that if a part of my treatment plan. I understand that what is shared in group must be kept confidential. It must not be shared outside the group with anyone unless the group as a whole gives permission. I understand that I may decline further participation at any time. I agree that no promises have been made to me as to the results of treatment or of any procedures. I understand that my treatment provider may have to consult with other members of my family or consult with other specialists concerning my treatment. Initial here: _____

LIMITS OF CONFIDENTIALITY I understand that all information regarding this work will remain confidential and will not be shared with others outside Stonebridge Ind Counseling Center, and other interagency approved persons or agencies without my consent. I understand that my counselor may receive supervision for my case and may need to discuss information about my case with the supervisor. I also understand that there are conditions under which this confidentiality must be broken and information be shared with the appropriate individuals. These conditions are as follows: a. If there is suspicion that a child is being abused; b. If there is evidence of physical abuse of elder or dependent adult; c. If I am making serious physical threats against others or myself. I understand that in cases of medical emergency, information sufficient to resolve the situation may be disclosed to emergency personnel, and I will be informed of this disclosure as soon as feasible. Initial here: _____

I understand that Jaime Theiss, LMFT, is committed to protecting my health information and that they follow the HIPAA guidelines for disclosing and protecting my PHI (private health information). I understand that a full copy of the HIPAA rules and regulations will be provided to me upon my request. Initial here: _____

FINANCIAL AGREEMENT I assign payment of all insurance benefits under all existing insurance policies to Jaime Theiss, LMFT. In the event that services are provided and are not covered by my insurance plans, I will be responsible for payment for these services. I understand that RCM Billing and Consulting submits claims directly to my insurance company on my behalf. **I understand that I am responsible to insure my claims are paid by my insurance**.
Initial here: _____

I understand that my co-payment, coinsurance and or deductibles are due at the time services are rendered. I understand that my insurance plans may have certain limitations on mental health benefits in the form of pre-certification, number of visits allowed or dollar amount per policy year as well as lifetime maximum benefits. I agree to accept full responsibility for charges once limitations have been reached. At any time during treatment, should I or my child(ren) become ineligible for insurance coverage, I will notify Jaime Theiss, LMFT and understand that I will become responsible for 100% of the bill.

I understand that, either late cancellation (less than 24-hours notice prior to the appointment time) or a “No Show” to a scheduled appointment will result in my being charged a $75.00 fee, due and payable before my next scheduled appointment. Exceptions will be given in cases of extreme emergencies or inclement weather. Your insurance plan does not pay for this fee. Initial here: _____

I understand that I am financially responsible for all charges whether or not paid by said insurance. Unless specific arrangements are made in advance a delinquent account (over 60 days past due) will result in my account being turned over to collections. If referred to collections, Jaime Theiss, LMFT reserves the right to charge a 30% collection fee. If I pay for services with a personal check, I understand that I will be charged a $25.00 returned check fee, if my check is returned by my financial institution/bank. Initial here: _____

ASSIGNMENT OF BENEFITS I authorize Jaime Theiss, LMFT to release any or all information pertinent to my treatment to my insurance companies for reimbursement and I hereby assign payment directly to Jaime Theiss, LMFT.

_____ _____
Signature of Patient/Parent or Guardian if Minor Child Date

Jaime Theiss, LMFT
3128 Hudson Crossing Bldg E Suite 1
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469-252-7090

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review carefully.

Introduction

Jaime Theiss, LMFT is required by law to maintain the privacy of your Protected Health Information (PHI). This notice provides you with information about your rights and my legal duties and privacy practices with respect to the privacy of PHI. "Protected Health Information" includes any identifiable information that I obtain from you or others that relates to your physical or mental health, the healthcare you have received, or payment for your healthcare. This notice also discusses the uses and disclosures I will make of your PHI. I must comply with the provisions of this notice, although I reserve the right to change the terms of this notice and to make the revised notice effectively for all PHI I maintain at that time. In the evet that the notice is changed, a new notice will be given to you at the time of your next appointment. You may request a copy of my Notice at any time.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to 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 Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Frank Clemente is not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions concerning or objections to this form, please ask to speak with Michelle Williams in person or by phone at 616-450-3360.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Signature: _____ Date: _____

Jaime Theiss, LMFT
3128 Hudson Crossing Bldg E Suite 1
McKinney, TX 75072
469-252-7090

Intake Inform

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Cell phone: _____

Work phone: _____ Home phone: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact & Phone Number: _____ _____

Name and relationship of emergency contact: _____

Insurance Carrier: _____ Policy #: _____

Group Number: _____

Policy holder name & DOB (if different than patient) _____ __/_ /___

Referred by: _____

Permission to text appointment reminders? Yes No Ph #: _____

Permission to call you at work? Yes No

Permission to call you at home? Yes No

Your Email Address: _____

Name of Spouse or Significant Other: _____

Name(s) and Ages of Children: _____

Please list any medications you are taking at this time: _____

_____

What brings you in for this visit? _____

Describe the problem you are experiencing which brought you in for this visit. (Next pg)

_____
_____
_____
_____
_____
_____
_____
_____

General Practitioner's Name: _____

Psychiatrist's Name (if applicable): _____

Technology Policy for Your Protection

I agree to use texting to communicate for the sole purposes of information related to appointment times, confirming appointments, stating the need to cancel or to convey I am running late on the way for our scheduled appointment, etc. For my protection and confidentiality, I understand that text and email communication is not to be used to convey clinical information.

Signature: _____ Date: _____

Office Information & Payment Policy

Welcome to my office. I hope that your visits here will be helpful. Please read what follows carefully, as it will help you use my services more effectively and feel free to ask any questions you may have.

I am a licensed Professional Counselor (LPC) providing services to help people resolve personal, relationship, family and work problems.

Office Hours: Hours by appointment. Calls will be answered by voicemail if I am unavailable. Please leave a message and I will return your call as soon as possible. Text messages requesting an appointment will also be returned by text or phone call.

Emergencies: In the event that emergency services are required and you are unable to reach me, please call 911 or go to your nearest emergency room.

Cancellations: If you are unable to make a scheduled appointment, please cancel 24 hours in advance to avoid being charged for a missed appointment. A late fee of $75.00 will assessed if your appointment is not cancelled within 24 hours.

Vacations: I will let you know in advance about scheduled absences from my office. Should an emergency arise in my absence and you are unable to reach me by text or phone, please contact the emergency number listed above or call my voicemail for the name and number of the designated on-call therapist stated in my 'out of the office voicemail' at that time.

I have read and understand the material above and have been given a copy of this form. I also acknowledge the material above and have been given a copy of this form. I also acknowledge receipt of copy of the HIPAA Privacy Information.

Patients signature: _____ Date: _____

Payment Policy

I understand that if insurance is being used, my co-payment and/or deductible is due when services are rendered. If I am a cash patient, I understand that all charges are due and payable when services are rendered.

I also understand that I am responsible for payment of all sessions scheduled, unless cancelled at least 24 hours in advance. If I fail to cancel my appointment 24 hours in advance, I will be responsible for the $75.00 "no show/late cancellation" fee.

I am a cash patient: I agree to pay $_____ per session.

Patients signature: _____ Date: _____

PATIENT RIGHTS & CONSENT TO TREATMENT

Persons seeking services are assured of these basic rights:

- The right to fully participate in treatment planning.
- The right that all information and participation in treatment will remain confidential and privileged and may be released only as authorized by law or with the patient's written consent. Treatment information may also be used for purposes of professional consultation, which is also held as confidential by consultants.

Exceptions to this right are:

1. When a person is a danger to himself or herself;
2. When a person is a danger to others or
3. When there is unreported child or elder abuse,

In which case, notification of proper authorities must take place by law. Other exceptions include cases when the patient's therapist or patient's records are subpoenaed by a court of law.

- The right to be informed in advance of charges for services.
- The right to all available services without discrimination because of race, creed, color, sex, age, handicap or national origin.
- The right to referral to other providers of mental health services.

I have read the above patient rights or have had them read to me. I fully understand my rights as a patient of Frank Clemente, including the right to and limitations of confidentiality. I hereby request services from Jaime Theiss, LMFT.

Signature: _____ Date: _____

STONEBRIDGE
INDEPENDENT COUNSELING CENTER

3128 Hudson Crossing Bldg E Suite 1
McKinney TX 75070
469-252-7090

24 Hour Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's scheduling needs and keeps the counseling center operating at it's most efficient level. Missed appointments are a significant inconvenience to your counselor, and other clients.

This policy is in place out of respect for our therapist AND our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot and leave a 60-minute hole in your therapist's schedule.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Clients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be charged for the session reserved. (48 hours or more notice is preferred if possible)

2. We reserve your appointment time just for you. 24-hour notice allows us to offer that time to other clients.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.

Thank you for providing our office and our clients with this courtesy!

I_____, understand this policy and authorize Stonebridge Independent Counseling Center to keep my credit card provided on file (encrypted and secure) and to be drafted only when services are rendered, or in situations where a 24-hour cancellation notice or no-show has occurred.

I authorize the above named business/counselor to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of service indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Print Name: _____

_____ _____
Signature Date

Billing Address _____ City, State, Zip _____

Phone# _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account Number _____ Expiration Date _____

CVV (3-digit number on back of card) _____

_____ _____
SIGNATURE DATE