Shannon L Deitch, M.S., LPC

Office Practices and Polices:

Please Read the Following Pages Carefully.

The information below is intended to inform you about office practices and policies. Because your relationship with me is based on confidence and trust, it is important that you be fully informed of some of the key elements of that relationship. Though the following list may be daunting, please be assured I will be happy to discuss these issues in detail so that you may feel comfortable with them. This form also serves to document that these issues have been discussed.

I have an independent private practice, and while I share office space with other mental health practitioners, each clinician represents an independent private practice.

Emergencies Messages can be left on my voice mail by calling 281-585-0000. Calls are returned between 8:00 a.m. and 6:00 p.m., Monday-Friday. After hour calls are reserved for urgent situations ONLY. If you have an ***urgent*** situation and must speak with me immediately, please leave a message on my voice mail and state it is urgent. I will call you back as soon as possible. I recommend that you dial 911, go to your local emergency room or contact your primary care physician in life threatening emergencies._____Initials _____ Date

Goals of Therapy Goals of treatment will be developed in discussion between myself, Shannon L Deitch, and you. Therapy is a joint effort between the therapist and the client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, consistent attendance, work outside of therapy (assignments) and other life circumstances such as interactions with family, friends, and other associations. It is important to review the work toward meeting these goals and make revisions as needed._____Initials _____ Date

Appointment Times Appointment times are limited. Each additional session is **45-50 minutes** unless special arrangements are made. The first **40-45 minutes** are spent addressing the presenting problem with the last **5 minutes** used to summarize the session and plan for future sessions. _____Initials _____ Date

Missed Appointments If you are unable to keep your appointment, please call at least 24 hours in advance. You are responsible for rescheduling missed or cancelled appointments. Appointment times are reserved for you. If appointments are **NOT** canceled 24 hours in advance: **You will be charged a $30.00 No Show/Late Cancellation fee which is due prior to or at the time of your next appointment.** Please note: two cancelations of appointments or no shows will result in the scheduled appointment time being released to other clients. ___Initials ___ ___Date

Fees and Payment Information My professional fee is $125.00 for the initial interview, $100 .00 for a 45-50 minute session, and $60.00 for 30 minutes. Different fee arrangements have been negotiated with some insurance companies. Payments for services or insurance co-payments/deductibles are discussed at your first session. Occasionally, co-pays/deductibles are not available until after the first billing and you are responsible for any difference. The following fees are paid by the client and cannot be billed to your insurance/EAP: *$30.00 for No Show/Late Cancellation, $100.00 for Letter of Treatment Summary for Legal Purposes, $400.00 plus travel for Court Appearances plus $100.00 per hour over 3 hours, $20.00 plus $1.00 per page over 10 pages for Copy of Treatment Records (except for continuity of care), $30.00 charge for returned checks, $30.00 per 15 minutes for after hours, non-emergency phone consultation.*
Payment may be by cash, check, or credit card and is due at the time services are rendered. *I reserve the right to seek collections for delinquent accounts. I will work with you in every way possible to avoid such an event.* _____Initials _____Date

Confidentiality The information you provide to Shannon L Deitch and to those under her supervision is confidential and will generally be released to others only with your written consent. However, I am required by law to disclose confidential information even without your consent in certain circumstances. These circumstances include but are not limited to the following: *If I consider you to be a danger to yourself or others; if you are a minor, elderly or have a disability and I believe you are a victim of abuse; if you report to me that a previous helping professional engaged in a sexual relationship with you; if you are involved in any suit or court proceeding affecting the parent/child relationship; if you file suit against the therapist for breach of duty and if court order or other legal proceeding or statue requires disclosure.*

If you chose to file insurance or work with a managed care company or EAP information regarding your treatment, diagnosis, and the specified issues for which you have come to treatment are available to the insurance company, managed care company or EAP. Health insurance companies often require that I diagnose your mental conditions and indicate you have an "illness" before they will agree to pay for services. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I summit it to the health insurance company. Any diagnosis made may become a part of your permanent insurance records. Once the information is turned over to the insurance company, managed care company or EAP, I have no control over how the information may be used. You have the opportunity to discuss with me any questions you may have on the limits of confidentiality. Please also refer to the HIPAA Regulations. _____Initials _____Date

Court Appearances My focus in providing psychotherapy is on treatment and on healing. It is not my intention to become involved in cases that require my testifying in court. However, should this service be needed, forensic or legal work in terms of paperwork, research, preparation and calls will be billed at my standard rate of $100.00 per hour. Court appearances will be billed to the client or the client's attorney at a rate of $400.00 plus travel for Court Appearances plus $100.00 per hour over 3 hours. _____Initials _____Date

Management of Records In the unlikely event of this provider's death I do give permission for any and all records to be turned over to the care and responsibility of Patricia L. Hayden, attorney for Shannon L Deitch, M.S., LPC. If this provider and her attorney were to die together, I give permission for any and all records to be turned over to colleague Bonnie Mondragon, M.S., LPC immediately. These records will be kept according to the guidelines of The Texas State Board of Examiners.
_____Initials _____Date

I have read and agree to the above polices. Signature:_____ Date: _____

105 N. Gordon St. Suite 202 · Alvin, TX 77511 · Phone: 281-585-0000 ext. 3 · Fax: 281-585-0080

Professional Statement

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a licensed professional counselor in the state of Texas. I hold a Master of Science degree in Counseling from the University of Houston – Clear Lake and a Bachelor of Arts degree in Psychology from the University of Wisconsin. I primarily see individuals age 4 through 18 years with developmental, behavioral and/or mental health disorders.

I have been professional counselor since 2008. I primarily work with children and adolescents in giving them the tools they need to succeed throughout life's struggles. A variety of therapeutic techniques are used to connect with each individual child. These include Cognitive Behavioral Therapy, Client Centered Therapy, Play Therapy, traditional Talk Therapy, and a variety of techniques.

Although our sessions may be very intimate psychologically, it is important for you and your child to realize that we have a professional relationship rather than a social one. Living in a small town and being part of community activities can sometimes make it difficult to maintain a professional relationship. Please be aware that we will always treat our confidences and therapy relationship separate from other community involvements.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Professional Counselors in Texas at 1-800-942-5540.If you have any questions, feel free to ask.

Client/Counselor Contract and Acknowledgements

I _____ commit to enter into a counseling relationship. In doing so I am personally committing to do the following:

A. Keep all scheduled appointments unless circumstances beyond my control prevent my attendance. I will be responsible for rescheduling missed appointments.

B. Participate in the counseling process honestly and to the best of my ability.

C. Complete any self-help assignments that I have agreed to carry out.

D. Apply any skills that I have gained to improve the quality of my life and the life of those around me.

E. I will notify my therapist of any significant changes or problems that may impact my work in therapy.

Acknowledgement: I have read and understand the Client Information on Office Practices and Polices, the Professional Statement, and the Client/Counselor Contract and I recognize that I have the opportunity to discuss any questions I may have.

Management of Records: In the unlikely event of this provider's death I do give permission for any and all records to be turned over to the care and responsibility of Patricia L. Hayden, attorney for Shannon L. Deitch, M.S., LPC. If this provider and her attorney were to die together, I give permission for any and all records to be turned over to colleague Bonnie Mondragon, M.S., LPC immediately. These records will be kept according to the guidelines of The Texas State Board of Examiners. By signing below you are acknowledging that you agree with this practice.

Client Signature: _____ **Date:** _____

I am signing as Parent, Guardian or Legal Representative.

Representative Signature: _____ **Date:** _____

Representative Relationship to the Client: _____

Counselor: _____ **Date:** _____

Notice of Privacy Practices- Brief Version

THIS NOTICE DESCRIBLES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This handout is a shorter version of the full, legally required NPP which you may request to review for more information. However, I can't cover all possible situations so if questions arise please talk to me about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP, I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign the form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Of course I will keep your health information private but there are some times when the laws require me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. Ask me to arrange how to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post the new version in the waiting area and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact Shannon L. Deitch (Privacy Officer) who can be reached by phone or mail at the above number and address.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.

Shannon L Deitch, M.S., LPC

Washington, D.C. 20201
(202)-619-0257
Toll Free: 1-877-696-6775

The effective date of this notice is April 14, 2003.

Consent and Disclosure

(protected health information for treatment payment or health care operations)

This form is an agreement between you, _____ and Shannon L. Deitch, M.S., LPC. When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here: _____ When I examine, diagnose, treat or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information and send to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read the Notice of Privacy Practices before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I CANNOT treat you.

In the future I may change how I use and share your information and so may change my Notice or Privacy Practices. If I do change it, you can get a copy from me by calling me at the above number or by asking me in person.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signatures for Consent to use and disclose your protected health information for treatment, payment or health care operations and verification that Notice of Privacy Practices – Brief Version was received:

_____ _____

Signature of client or his or her personal representative **Date**

_____ _____

Printed Name of the client or personal representative Relationship to the client

_____

Description of personal representative's authority

_____ _____

Signature of Counselor **Date**

Insurance

Client Information_Assignment of Benefits_Release of Information

TODAY'S DATE _____ FIRST APPOINTMENT DATE _____

CLIENT NAME: _____ _____DOB: _____ □ MALE □ FEMALE

PATIENT SOCIAL SECURITY NUMBER: _____

HOME NUMBER:_____ CELL NUMBER:_____ OTHER NUMBER:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

□ FULL TIME STUDENT □ PART-TIME STUDENT □ EMPLOYED

MARITIAL STATUS: □ SINGLE □ MARRIED □SEPERATED □DIVORCED □ WIDOWED

REFERRAL SOURCE: _____

INSURED'S NAME: _____DOB: _____□ MALE □ FEMALE

INSURED'S SOCIAL SECURITY NUMBER: _____

HOME NUMBER:_____ CELL NUMBER:_____ OTHER NUMBER:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

RELATIONSHIP TO CLIENT: □ SELF □ SPOUSE □ CHILD □ OTHER: _____

INSURED'S EMPLOYER: _____

INSURED'S ID NUMBER: _____ GROUP NUMBER: _____

INSURANCE COMPANY: _____ INSURANCE PHONE NUMBER: _____

□ HMO □ PPO □ EAP □ INDEM □ PSO □ WC □ MEDICAID

EFFECTIVE DATE:_____

Release of Information: I authorize the release of any medical information, including diagnosis, or other information necessary to process this claim for services. I realize Shannon L Deitch, M.S., LPC may be required to release parts of my record and/or discuss my case with my insurance carrier or authorized insurance review committee to receive payment, obtain additional authorization for services, or for case audit. I also request payment of government benefits either to myself or Shannon L. Deitch, M.S., LPC.
Client or Authorized Persons Signature_____

Assignment of Benefits: I authorize payment of medical benefits to Shannon L. Deitch, M.S., LPC for services provided. I understand I am financially responsible for charges not covered by insurance (co-pays. percentages, deductibles, no-show fees when applicable, or non-payment due to failure to provide information regarding changes in insurance coverage). I understand that Shannon L. Deitch, M.S., LPC reserves the right to seek collections for balances due by me.
Insured's or Authorized Persons Signature_____

PATIENT REQUEST FOR DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request confidential communications of Public Health Information (PHI) be made by alternative means such as sending correspondence to the individual's place of employment instead of their home. All efforts will be made to comply with these requests. **I wish to be contacted in the following manner:**
Detailed messages may be left on answering machine, voice mail or with a person at the following number(s):_____
Please indicate if home, cell, work or other number. Written communication may be mailed to: _____
Information may be faxed to:_____

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.

(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

Your log in is_____

Your password is_____

Shannon L Deitch, M.S., LPC

CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____

I give my permission for Shannon L. Deitch, M.S., LPC to provide/receive information concerning my treatment to/from

_____

Address: _____

Phone: _____ Fax: _____

_____ I do not wish treatment information to be given to my Primary Care Physician.
_____ I do not wish treatment information to be given to my Psychiatrist.

_____ _____
Client Signature Date

(OFFICE USE ONLY)

To: _____

From: Shannon L. Deitch, M.S., LPC
I am currently seeing the patient named about for:
_____ Individual Therapy _____Marital Therapy _____Family Therapy

The patient's initial Axis I diagnosis is:
_____ Major Depressive Disorder_____
_____ Bipolar Disorder_____
_____ Generalized Anxiety Disorder_____
_____ Adjustment Disorder with _____
_____ Other: _____

I have requested that the patient see you for:
_____ Evaluation for psychotropic medication
_____ Medication Management issues
_____ Physical Examination/Lab Work _____
_____ Other: _____

Other Concerns/Issues:
_____ This is for information only _____Description of concern/issue
_____
_____
__

Signature:_____ Date:_____