Keller Psychological Associates, PA
Ray Austin, Psy.D., PA

CONSENT TO OUTPATIENT THERAPY

This document contains important information about my professional services and policies. Please read it carefully and write down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, as well as the particular problems you bring forward. There are many different methods I may use to deal with the issues that you hope to address. Psychotherapy is not like a visit to your medical doctor. Instead, it requires a very active effort on your part. In order for therapy to be most successful, you will have to work on things that we discuss both during our sessions together and at home.

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. On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy often contributes to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience in therapy or of what you may gain from it.

Our first few sessions will involve an evaluation of your needs. By the end of this evaluation, I will be able to offer you some initial impressions of what our work together will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. 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 my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

I normally conduct an *initial evaluation* that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 to 50-minute session at a frequency that we agree upon.

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. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you do not have insurance, or I am not an in network provider, you will be expected to pay the full fee at the time services are delivered.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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, I have no control over what they do with it once it is in their hands.

CONTACTING ME
I meet with clients throughout the day so I will be able to answer the phone only intermittently. I can be reached through my voicemail and I will make every effort to return your call on the same day that you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

PROFESSIONAL RECORDS
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your child's records, or I can prepare a summary for you instead (psychotherapy notes are not a part of the medical record). Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests (photocopying records, chart review).

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY
Dr. Austin will not release information about you to another party unless:
1) You authorize him to do so in writing (you may revoke this at any time afterward).
2) He has reason to believe that you pose an imminent risk to your safety or the safety of an identifiable person(s).
3) You disclose that a child under the age of 18, an elderly person, or a disabled person Is or has been physically or sexually abused by you or someone you know.
4) He is required by a court of law to disclose information (for example, if you use your mental health treatment as a defense in legal proceedings).

DIVORCE AND CUSTODY DISPUTES
Although my responsibility to your child may require my involvement in conflicts between you and your (ex)spouse, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final

decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

By signing below, I attest that I have read the terms of this consent form and have been given an opportunity to ask questions.

____ ____________
Signature of client or legal guardian Date

____
Printed name of client

Keller Psychological Associates, PA
Ray Austin, Psy.D., PA

Acknowledgement of receipt of Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

Your signature below acknowledges your receipt of the *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information* (referred to as the "Notice") for the office of Ray Austin, Psy.D., PA.

____________________________________ ____________

Signature of client or legal guardian Date

____

Printed name of client

I hereby permit Dr. Ray Austin to release and furnish all medical and financial data related to my care that may be necessary for the collection of data for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO and PPO managed care organizations contracting with any of the above entities to perform such functions.

____________________________________ ____________

Signature of client or legal guardian Date

____

Printed name of client

You have the right to request that Dr. Ray Austin restrict uses and disclosures of your health information; however, Dr. Austin is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that Austin has previously taken action in reliance to this consent. Your treatment is conditional in your signing this agreement.

Keller Psychological Associates, PA
Ray Austin, Psy.D., PA

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage.

Insurance Company name or Mental Health Network:____________________________________

Phone number from insurance card: ____
(Please make sure to write down the number for mental health/substance abuse services)

Employer: ____

Address:____

City:_______________________ Work Phone:____

Primary Cardholder's Name: ____

Primary Cardholder's SS#:____

Primary Cardholder's date of birth: _______________________________

I.D. Number:_____________________________ Group Number:__________________________

Authorization number (if you have one): _______________________________________

Please bring your insurance card and driver's license to the first appointment so copies can be made

AUTHORIZATION AND RELEASE

1. I authorize use of information on this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to Ray Austin, Psy.D.,1858 East Keller Parkway, Suite D Keller, Texas 76248
5. I hereby permit a copy of this to be used in place of an original.
6. It is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance the day and time that services are provided.

Signature of client or Policyholder:____

Date:______________________

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PAYMENT POLICY

1. **Full payment for each session is required at the time the service is rendered.** Payment may be made by **cash, check or credit card**. A co-payment of insurance will be accepted after insurance coverage is verified.

2. Filing of insurance is a courtesy provided by this office. If you prefer to file your own claim, a duplicate receipt will be provided.

3. There will be a **$30.00 fee** for any **NSF check returned**.

4. Your session time is reserved specifically for you. If you are unable to keep your appointment, please notify us by phone **at least 24 BUSINESS hours in advance.** In the absence of 24 business hour notification, you will be billed the insurance contracted fee amount for the session. *Missed appointments cannot be filed with insurance.*

Fee Schedule

Service	Fee
Initial Consultation / Intake (60 minutes)	$160.00
Therapy session (45-50 minutes)	$140.00
Psychological Testing (includes test administration, scoring and interpreting tests, as well as report writing time)	$150/hour
Interpretative session (review test results)	$140.00
Review of clinical records / Consultation	$100/hour
School observation (includes travel time to and from)	$150/hour
Court preparation	$250.00/hour

I have read, understand, and agree to abide by the above stated fee policy.

Signature of patient or policyholder: ____

Printed name of patient or policyholder: _____________________________________

Date: __________________

1858 East Keller Parkway, Suite D
Keller, TX 76248
817-726-0015

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CANCELLATION POLICY

The time you have reserved for a session is one for which you are financially accountable. If you should need to cancel or reschedule your appointment, please call our office **24 BUSINESS hours in advance**, and we will happily accommodate your needs. If it is difficult for you to call during regular office hours, please leave a voice message. We will respond to your call at the earliest opportunity the next business day.

For cancellations with less than 24 business hour notice, or no-shows, you will be charged the entire insurance contracted fee amount for the session. If you are self-paying, you will be charged the standard fee you are paying for each session. These appointments cannot be filed with insurance.

Signature of client or policyholder: ____

Printed name of client or policyholder: _____________________________________

Date: ________________________