**STEP BY STEP COUNSELING CENTER**

3605 W. Pioneer Parkway, Ste. A-5

Arlington, TX 76013

PHONE: (817)538-5998 FAX: (817)538-5998

## WELCOME TO STEP BY STEP COUNSELING CENTER!

*PLEASE BE ADVISED THAT ALL INFO WILL BE KEPT CONFIDENTIAL*

### PATIENT INFORMATION

PATIENT NAME:_____DOB:_____

_____

ADDRESS:_____CITY/STATE:_____ZIP:_____

SOCIAL SECURITY #:_____CELL#:_____ALT #:_____

PT'S PCP/PCM:_____PHONE#:_____FAX:_____

_____

HAS PATIENT EVER RECEIVED PSYCHIATRIC CARE? (COUNSELING, MEDS, HOSPITALIZATIONS) ___ YES ___ NO

IF YES, W/ WHO?_____PHONE#:_____FAX#:_____

_____

WHEN WAS THE PT LAST SEEN:_____

### IF PATIENT IS A MINOR

NAME OF SCHOOL:_____GRADE:_____

_____

PARENT/GUARDIAN:_____PHONE#:_____WORK #:_____

### IN CASE OF EMERGENCY

CONTACT PERSON:_____RELATION TO PT:_____

PHONE#:_____ALT#:_____

_____

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***WHO REFERRED YOU TO OUR OFFICE?**

_____

**WHAT IS THE REASON YOU'RE SEEKING COUNSELING: (CHECK ALL THAT APPLY):**

___ ADHD ___ COURT ORDERED ___ BIPOLAR D/O ___ ANGER MGMT ___ DEPRESSION ___ MEDICATION ___ ANXIETY ___ COUPLES COUN.

___ OTHER:
(EXPLAIN):_____
_____

*IF YOU ARE HERE FOR COUPLES COUNSELING, PLEASE WRITE THE NAME OF YOUR SPOUSE:

NAME:_____DOB:_____PHONE#:_____
_____

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## "NO SHOW/CANCELLATION/RESCHEDULING POLICY"

**All** appointments **MUST** be **confirmed** with office staff in order to remain on counselor's schedule- either via AUTOMATED reminder system OR via calls made by our office staff. PLEASE call our office with as MUCH advance notice as possible if you cannot make your scheduled appts. We will gladly reschedule your appointment if you give advance notice.

**Remember- the "reminder calls"** made by our office staff are **ONLY A COURTESY** to our patients. We may not always have the time to make reminder calls and this is why we provide you with a "reminder card" showing your next appointment date and time. YOU are responsible to get a reminder card from the front staff for each and every appointment.

If you are UNABLE to attend your scheduled appointment, we **REQUIRE 48 hour notice** in order to replace your slot with another client. If you have more than **2** no shows, reschedules or cancellations **WITHOUT** 48 hour notice,there will be a $60 fee assessed to your account and after 3 no shows or missed appts., we will be forced to close your case and you will be referred to another counseling center. You can return to our agency after 6 months time **if** there is availability.

We also ask that you spend some time discussing with the front check out staff your appointment times and dates so that you can plan accordingly. We try to work with each patient/ family to give them the best time and dates so that all appointments can be kept. You can also schedule 3-4 appointments in advance if there is a particular time slot you require. Remember that if you do not show up to your appointment or call to cancel at the last minute, you will be charged a "fee". You must pay this fee prior to being seen for next appt.

*By signing this form, I am stating that I have READ ALL THE ABOVE POLICIES and am in agreement to following them*

_____ _____

**Patient or Parent Signature** **Date**

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# Office Policies and Information

This document contains important information about the services offered to individuals and outlines the policies and procedures that underlie the delivery of those services. This document also contains a summary of Health Insurance Portability and Accountability Act (HIPPA Act), a new federal law that took effect on April 14, 2003. HIPPA provides new privacy protections and patient rights with regard to use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment for services and healthcare operations. It also goes over office information and policies for counseling at Step by Step Counseling Center.

## About the Therapist/Counselor

Therapeutic services are provided by TAMMY L. BOTELLO, LPC-S who hold a Master's Degree or higher in Counseling or similar mental health fields. Our counselors come from various backgrounds and are happy to share that information with you.
**_____PATIENTS INITIALS**

## Contacting your Counselor Outside of Session

Our office is typically open BY APPT ONLY and we are available by apt. only. Evening and weekend appts. are available by appt.. When your counselor is unavailable, messages can be left with front desk or on the confidential voicemail at 817-538-5998. Generally, calls are returned within 24 hours, with the exception of holidays and weekends. In emergency situations, please contact the office first and if there is no one available to answer your call, please contact your family physician or go the nearest emergency room or dial 911 and ask for the psychiatrist on call. **_____PATIENTS INITIALS**

## Paperwork Fees:

We reserve the right to charge the following fees for different types of paperwork:

| | | |
|---|---|---|
| Copies of medical records | $1.00 per page | |
| Letters for court, attorneys, school, etc. | $25 | |
| Social Security paperwork | $50 | |
| F.M.L.A. paperwork/letters | $60 | |
| Disability paperwork/letters | $60 (EACH SET OF FORMS) | **_____PATIENTS INITIALS** |

## Insurance Clients

Individuals with Medicaid or private insurance should make every effort to insure that their insurance remains ACTIVE during the course of their counseling. Non-active patients will require that their counseling be placed on hold until the insurance reactivates. If the patients' well-being is at risk, they may choose to pay the cash pay prices until their insurance is active again.
**_____PATIENTS INITIALS**

## Court Fees

If a therapist is required to be present in court for a legal matter relating to your counseling, the fee for this is **$1200.per day** and **must be paid PRIOR to court date.** The fee for each additional day is $600 regardless of the time spent in court. This fee ensures that the therapist will cancel all that day's appts. and be present in court for the required time. It is not necessary to subpoena the counselor if arrangements have been made prior to court. For CPS cases, this fee is paid by the department per our contract with that agency. The counselor may be asked to be physically present in court or may be asked to testify via phone conference with the judge. The fee remains the same. **_____PATIENTS INITIALS**

## Limits of Confidentiality

*Child abuse/neglect
*Elderly and/or handicapped abuse/neglect
*To avert a serious threat to health or safety of oneself or other individual
*Health risk issues
*Judicial and administrative proceedings, required by law
*Worker's compensation cases
*Consultation with other health professionals that benefit the client—clients identifying information may remain anonymous at times or may be disclosed if it is in the best interest of the client.

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## Patient's Rights

HIPAA provides patients with the following rights with regard to their clinical records, "PHI" "Personal Health Information:

*Request limitations on disclosures of the PHI
*Request alternative channels of communication
*Review health information records, including psychotherapy notes
*Ask for a copy of their records
*Request that their records be amended or corrected
*Ask for an accounting of disclosures of PHI
*Determine location (s) to which PHI are sent
*File a complaint with regard to privacy violations

## Therapist Responsibilities

*Counselors are required by law to maintain the privacy of PHI and to provide patients with notice of their legal duties
*The counselor may reserve the right to change the policies or practices in this notice, with notice to the client in open area of office.

## Services for Children/Minors

If patient is under the age of 18 and not legally emancipated, they should be aware that the law allows parents to examine their child's treatment records, unless the counselor believes that such a review would be harmful to the patient and to his/her treatment. Before providing any information to parents/guardians, counselors will discuss the need to do so with the patient and if possible, respond to any objections raised by the parent. For parents that are divorced or do not live together with child, the office reserves the right to review legal paperwork showing that they have rights to access medical records and/or counseling (psychological services) for the child. We cannot release records to anyone unless they can show proof of having the right to access that information.
I verify that I am the legal guardian or parent, managing conservator, or person designated by the court to have the authority to consent to provide psychological services for the child listed below. I represent that I am authorized to grant this consent for professional services and request that therapeutic services be provided for my child.

_____ _____

**Child's Name** **Parent/Legal Guardian Signature**

### Team Approach

During the time you or your children are in counseling at our office, you may be seen by a substitute therapist or other team therapist. This could be as a result of a counselor's absence, sick leave or vacation time. We make every effort to keep you and your family with the same counselor during the entire course of your treatment, however, there may be reasons beyond our control that require that you be transferred or seen by a different counselor. Also, please discuss any concerns about your counselor with front staff, including if you are not comfortable or happy with your current therapist, so that you can be changed to a different therapist. We try to make every effort to keep our clients happy with their counseling experience. **_____PATIENTS INITIALS**

## Consent for Treatment

I have read, understand, and have asked any questions I have regarding this document given by Step By Step Counseling Center staff. I have also read, understand and have received a copy (if requested) of the Notice of Privacy Procedures, which is in accordance with the HIPAA Act. **_____PATIENTS INITIALS**