Laura D. Fleming, MS, LPC

6300 Ridglea Place, Suite 212, Fort Worth, TX. 76116 (817) 925-6563/fax (817) 731-7895

www.LauraFleming.com

Outpatient Services Contract for Adolescents

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our initial meeting. When you sign this document, it will represent an agreement between us.

Counseling Services Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling 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 at home. It is important that you take an active role in the process. This involves keeping scheduled appointments, listening to the counselor, being hones, discussing the counseling process, and completing agreed upon assignments. Counseling can have benefits and risks. Since counseling 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, counseling has also been shown to have benefits for people who go through it. Counseling 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 or specific results.

Meetings The initial consultation lasts 53-minutes and consists of a review of this contract, answering any questions and identifying a presenting problem. We will conclude the initial session with a preliminary treatment plan. I 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 with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money and energy, so you should be very careful about the counselor 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. After counseling has begun, I will usually schedule one 53-minute session (one appointment hour of 53 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. The first few sessions will involve the continued evaluation of your needs in conjunction with therapy. On the fourth session there will be a review of the treatment plan and goals may be adjusted.

Clients initials _____

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24- hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, I will try to find another time to reschedule the appointment. If you miss a scheduled appointment and do not call the office within seven days I will consider this your notice of termination of services. You may reinstate services at any time by making another appointment.

Professional Fees My hourly fee is $95. I accept personal checks, cash, Visa, MasterCard and Discover. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour (with a guarantee of $800) for preparation and attendance at any legal proceeding. Payment for legal services is due at time of scheduling.

Billing and Payments You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Insurance Reimbursement *BEGINNING JUNE 1, I will no longer accept insurance reimbursements.*
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 currently am not accepting insurance payments. I do not bill insurance companies. I will 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.

Clients initials _____

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. 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 I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should be aware that there are certain potential risks associated with filing mental health insurance claims. When filing a claim, the therapist must submit a formal diagnosis. This diagnosis then becomes part of your permanent medical record. This often results in the insurance company labeling the consumer with a "pre-existing condition." For example, if your therapist submits a diagnosis of "depression," this pre-existing condition can later raise your life insurance premiums or make it difficult to obtain health insurance.

Contacting Me When you telephone me, I will personally answer the phone if available. I am usually available between 9am and 5 pm Monday through Friday, but will not answer the phone when with a client or consultation. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return you call on the same day you make it, with the exception of weekends, holidays and after hours. If you are difficult to reach, please inform me of some times when you will be available or alternate telephone numbers. In emergencies, if you are unable to reach me and feel that you can't wait for me to return you call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call or dial 9-1-1. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Complaints An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas, 78714-1369 or call 1.800.942.5540 to request the appropriate form or obtain more information. This number is for complaints only.

Professional Records The laws and standards of my profession require that I keep treatment records for five years past the last time we meet. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. I am sometimes willing to conduct a review meeting without charges. Clients will be charged an appropriate fee for any time spent in preparing information requests. There is no charge for records sent to another mental health

Clients initials _____

professional. By signing this contract you authorize Laura Fleming, MS, LPC to name a properly qualified custodian to assume responsibility for these records in the event of Laura Fleming, MS, LPC's death or disability.

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 form 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. I which 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 In general, the privacy of all communications between a client and a counselor is protected by law, and I can only release information about our work to others with your written permission. But here are a few exceptions.In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

Clients initials _____

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I may be required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the client threatens to harm himself/herself, I am obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Clients initials _____

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____

Child's Name

_____ _____

Parent/Guardian's signature *Date*

_____ _____

Laura D. Fleming, MS, LPC *Date*

Laura D. Fleming, MS, LPC
2501 Parkview Drive, Suite 305 Fort Worth Texas 76102 (817) 925-6563/fax (817) 731-7895

Informed Consent

All information obtained from the interview and subsequent counseling sessions will be held strictly confidential, and shared only with professional personnel listed above ***EXCEPT*** in the case of a minor, or cases of harm to self or others, child abuse/neglect, or court order (in which disclosure to appropriate authorities is required by law).

****

I, _____, understand the nature and purpose of the counseling and interview. I understand that I may ask questions at any time.

Child's Name: _____ Date: _____
Signature of Parent/Guardian : _____ Date: _____
Witness: _____ Date: _____

Rev. 1/09

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Fee Agreement

Fees are charged as follows:

Individual, couple or family counseling	53 minute session	$95.^{oo}
EMDR	90 minute session	$145.^{oo}
Specific Tests (Includes test materials and brief written report)	varies	$25.^{oo}-$150.^{oo}
Court Appearances (Because of the difficulty of legal involvement, I charge $100.^{00} per hour for preparation and attendance at any legal proceeding.)	per hour	$200.^{oo} Minimum payment of $800.^{oo}
Professional Consultation	per hour	$95.^{oo}

As a courtesy, I will bill your insurance company or third-party payer for you, if requested. In the event that the claims are denied, it is the client's responsibly to pay the balance due.

I agree to the fee schedule listed above:

_____	_____
Parent/Guardian Signature	Witness Signature
_____	_____
Date	Date

Laura D. Fleming, MS, LPC

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations with your consent. To help clarify these terms, here are some definitions:

- "PHF" refers to information in your health record that could identify you.
- "Treatment" is when the practitioner (me) provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a mental health care provider consults with another health care provider, such as you family physician.
- "Payment" is reimbursement for your healthcare. Examples of payment are the disclosure of PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of a mental health practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. These activities include paper and electronic transmissions of PHI, such as filing insurance or sending a fax.
- "Use" applies only to office activities such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to actives outside of the of the office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In that instance when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain authorization from you before releasing this information. I will also need to obtain an authorization before releasing your therapy notes. "Therapy notes" are notes I have made about our conversation during an individual, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorization (of PHI or therapy notes) at any time, provided each revocation is in writing, You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may us or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have cause to believe that that a child has been, or may be, abused, neglected, or secularly abused, I must make a report of such abuse within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, wel must immediately report such to the Department of Protective and Regulatory Services.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier and your treating doctor.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

- *The Right to Request Restrictions*. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *The Right to Receive Confidential Communication y Alternative Means and at Alternative Locations.* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, I will send your bills to another address.)
- *The Right to Inspect and Copy.*You have the right to inspect or obtain a copy ((or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. This request must be made by you in writing. A fee will be charged by my office to cover the expenses of reproducing the records. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *The Right to Amend.* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *The Right to an Accounting.* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this notice). On your request, I will discuss with you the details of the accounting process.
- *The Right to a Paper Copy.* You have the right to obtain a paper copy of this notice from me upon request.

Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes; however, I am required to abide by the terms currently in effect. If I revise these policies and procedures I will supply you with notice of such revision in person during a session or by mail at the billing address which you have provided to me.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact Laura Fleming, MS, LPC at 817-925-6563. You may also send a written complaint to the Texas State Board of Counselors; Complaints Management and Investigative Section: PO Box 141369; Austin; Texas; 78714-1369/ or call 1-800-942-5540.

VI. Effective Date, REstrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2010.

Laura D. Fleming, MS, LPC

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

Mental health practitioners are required by Federal laws to provide you with written notice about how mental health and medical information about you may be used and disclosed and how you can get access to this information. Please sign below that you have received the attached notice. This signed page should be returned to me. Pleas read the attached notice carefully so that any questions you have may be discussed

I acknowledge receipt of this notice.

_____	_____	_____
Client's Name (Printed)	Date	Parent/Guardian's Signature

_____

Parent/Guardian's Name (Printed) If under 18 years old

Laura D. Fleming, MS, LPC

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

(Without your authorization I cannot bill your Insurance Company)

Client Name_____ Date of Birth_____

I request and authorize release of health care information of the client named above to:

Laura D Fleming, MS, LPC
6300 Ridglea Place, Suite 212
Fort Worth, Texas 76116

The request and authorization applies to:

Mental healthcare information related to current treatment with Ms. Fleming.

Signing this form authorizes the release of any records regarding mental health treatment of the persons listed above.
Initial____

(Without your authorization I cannot bill your Insurance Company)
THIS AUTHORIZATION EXPIRES WHEN THERAPY IS DISCONTINUED.

I hereby acknowledge that I have been presented with a copy of the HIPPA notice of privacy practices.

Client Signature_____ Date of Birth_____

Laura D. Fleming, MS, LPC

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BIOGRAPHICAL INFORMATION

Name (adolescents information)_____

Address:_____

Street City Zip

Phone: _____

Cell

Date of Birth: _____ Age:_____

Person responsible for charges: Relationship to client: _____

Name:_____

Address:(if different from child)_____

Street City. State. Zip

Cell Phone: _____ Date of Birth _____

Yes, you may leave a message on the following phone numbers:

_____

_____ _____

Signature *Date*

If you wish to file an insurance claim, please complete the following

Insurance provider:_____

Insurance ID:_____

Group #:_____

Name of insured:_____

Date of Birth of insured:_____

Laura D. Fleming, MS, LPC

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INTAKE FORM FOR ADOLESCENTS

The following background information is required to accurately assess the applicant. Please fill out completely. You may use the back of the form or additional sheets of paper if necessary to provide all pertinent information.

Full name of child to be assessed_____

Home:

Father's Name: _____ Age: _____
Mother's Name: _____ Age: _____
Guardian's Name: _____ Age: _____
Brother or sisters:

Name	Age	Sex

With who does the applicant currently lives?_____
Does the child get along well with all members of the family? If not, please explain

_____
_____
_____

Have there been any changes in the applicant's home environment during the school years? For example, moves, parental divorce or marriage, parental or sibling death, etc. Please list all environmental changes and dates:

_____
_____
_____
_____

Medical:

Was the pregnancy with this child normal? Yes / No
If No, what was unusual about the pregnancy?

_____
_____
_____
_____

Pregnancy was: Full Term Premature (early) Postmature (late)
If early or late, provide details:

_____
_____
_____
_____

Birth was: Vaginal / Cesarean, If by cesarean: planned or emergency?
How long did the baby stay in the hospital? _____

Did the baby require Neonatal Intensive Care (NICU) Yes / No
If yes, how long? _____ For what reason?_____

_____
_____
_____

Developmentally did your child walk and talk at an appropriate age? Yes / No
If no, please provide details:

_____
_____
_____
_____

Has the applicant required speech, physical or occupational therapy? Yes / No
If yes, please provide dates and if therapy was successful.

_____
_____
_____

Has the applicant had seizures? Yes / No If yes, when did they start?
_____Altogether, how many seizures has the child had? _____
_____ Does the child still have seizures?_____ How often? __
_____ Have all the seizures happened when the child had a high temperature?_____

Starting from birth and proceeding up to the present, list all diseases, chronic or severe illnesses, important accidents and injuries, surgeries, hospitalization, periods of loss of consciousness, convulsions/seizures, and any other medical condition your child has had:

Date presented	Illness/accident/incident/etc	Length of Stay/period of time problem
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the applicant currently take medication? Yes / No

If yes, list all medication:

Medicine	DosageTaken	how often	Reason for medication
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____

Who is your child's pediatrician? _____ Last visit?_____
Other doctor's who care for your child_____Reason_____
Any concerns shared by the doctor?_____

Psychological:

Has your child previously been diagnosed with a learning difference i.e., ADHD, Aspergers Disorder, Dyslexia, etc? Yes / No
If yes, what diagnosis was made?_____
when was that diagnosis first made?_____
who made the diagnosis? _____
What treatments have been tried; please indicate success or failure of treatment?
Medication:_____
_____
_____
Behavioral treatment: _____
_____
_____
Routine: What kind of physical exercise does your child get? _____
Is your child involved in extra-curricular activities?_____
How would you describe you child's energy level?_____
How would you describe your child's eating habits?_____

How would you describe your child's sleep habits? _____
Bedtime _____Wake-up Time _____ Hours of sleep on an average night _____

Has your child had any substance abuse problem? Yes No
If yes, give relevant details: _____
_____
_____

Has your child been arrested? Yes / No
If yes, please provide relevant details: _____
_____
_____

If you wish to provide the results of previous psychological, developmental or educational assessments, indicate when and by whom the assessment was performed and the results:_____
_____
_____
_____

List all prior mental health professionals who have cared for your child:

Date	Name	Presenting Problem	Reason for Discontinuing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education:

Current Grade in School:____Name of current/most recent school attended:_____
Please described in chronological order all schools attended beginning with preschool and ending with most recent school. Include home schooling and any grade repeated:

	Year(s)	Grade(s)	School	Reason for Changing School
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

If your child has repeated a grade please explain the situation: _____
_____

List most recent coursework and grades received. Please explain if these scores were inconsistent with past performance:

Course	Grade	Comments
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please describe any behavior problems with school personnel or other classmates, and any other details you believe are important. Please include dates and reasons for suspension, detention, etc.:

_____
_____
_____

Has the applicant ever been assigned to Special Education courses? Yes / No. If yes, indicate the reason for the assignment and the years the applicant attended.

_____
_____
_____

Why are you seeking counseling for your child?

_____
_____
_____