Mary Damkroger, Ph.D.
Christian Psychological Services

AGREEMENT FOR PSYCHOLOGICAL SERVICES AND CONSENT FOR TREATMENT

Thank you for choosing me for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with my professional services and business policies, I am providing the following information:

Appointments: Appointments are made with at the end of a therapy session or by phone at 214.682.8764. Therapy sessions are 50 minutes in length. Double sessions are available in situations where it is beneficial. The number and frequency of sessions needed depends on many factors and will be discussed with you after our initial meeting. If you need to cancel an appointment, a minimum of 24 hours notice is required; otherwise you are subject to a $50.00 charge for the missed appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In some cases a phone appointment is a good alternative to canceling.

Contacting Me: Due to my work schedule, I am not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail. I will make an effort to return your call in a timely manner, that same day or the next. In the case of an emergency however, contact your family physician or the nearest emergency room and ask for the psychiatrist on call.

Financial Responsibility: You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other arrangements are made in advance. My regular fee is $130 for a 50 minute session and $260 for a double session (100 minutes). Payment options include cash, check or credit card; I accept Visa and MasterCard only, and prefer checks/cash if possible. There will be a $25 fee for payments returned as insufficient funds. If an account becomes significantly past due, correspondence regarding the pat due portion of the account balance will be done by a mailed statement or a phone call to the listed client/guarantor address or phone number listed on the Registration Form.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPAA), is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law protects the privacy of communications between a patient and a psychologist. Everything about your care will be held in the strictest confidence. In most situations, I can only release information about your treatment to others with your written signed consent. Possible exceptions to confidentiality include, but are not limited to the following situations: suspected or reported child abuse or abuse to elderly or disabled persons; imminent/serious threat of injury by you to yourself or others; court ordered legal proceedings. If you have any questions or concerns about confidentiality, it is important that you bring them to my attention in order that we may discuss them further.

In addition, it is important for you to know that your relationship with me will be a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships can undermine the effectiveness of the therapeutic relationship and are not permissible by the Texas State Board of Examiners of Psychologists.

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Insurance Reimbursement: For *non-contracted* insurance plans, you are required to make payment in full at the time of service and you may bill your insurance directly, with the completed fee ticket you receive. For *contracted* insurance plans, please verify your benefits and record this information on the *Insurance Verification Form* (provided on the website) and bring to the first visit. You are responsible only for the co-payment deductible and non-covered services as determined by your contracted insurance plan. I will submit the appropriate claim forms to your contracted insurance plan for reimbursement. You are responsible for notifying me immediately of any change in your insurance plan or coverage. *Insurance company-quoted benefits are not a guarantee of payment.*

You should be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Contact your insurance carrier if you have questions regarding how they handle your personal health information once it is received.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE ABOVE AGREEMENT FOR SERVICES AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT FROM MARY DAMKROGER, PH.D.
YOU MAY REVODE THIS AGREEMENT IN WRITING AT ANY TIME.

_____
Patient/Guardian Name (PRINT)

_____ _____
Patient/Guardian Signature Date

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

Patient:_____ Birth Date: _____
(First) (Last)

I certify that I am the __ father __ mother __ legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I, hereby, give my authorization and consent for the above named child/adolescent to receive outpatient treatment from Mary Damkroger, Ph.D.

_____
Patient/Guardian Name (PRINT)

_____ _____
Patient/Guardian Signature Date