Family & Youth Institute, LLC

# Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

## Welcome

You, or a member of your family, are about to engage in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed, and completing them as thoroughly as possible so that we miss nothing that may be important in your treatment.

## Consent to Treatment

I, _____, acknowledge that I have received, have read (or have had read to me), and understand the Client Information packet and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Family and Youth Institute, LLC. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided in therapy.

### Initial Session

My first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:

a) Type of therapy needed (individual, group, medication referral, etc.)
b) Frequency of therapy sessions (weekly, biweekly, etc.)
c) Goals of therapy (what you hope to gain from this process.)

### Appointments

Each individual appointment is approximately 50-55 minutes unless agreed to before the session. Couple's sessions are suggested to extend to 75 minutes. At the end of each appointment, you can discuss future appointments with your therapist.

I am aware that I may stop my treatment at any time. I will be responsible for paying for any services I have had already. I understand that I may lose other services or may have to manage concerns if I stop treatment. (For example, if my treatment has been court-ordered, I will answer to the court).

### Cancellation

I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed half the amount of the session. If the appointment can be rescheduled to a time within the week, that rescheduled session will be billed for the remaining half of the session rate. I have been given the opportunity to ask questions regarding this statement.

### Payment

All therapy services must be paid at the time of your appointment unless otherwise arranged with your therapist or office manager. If you do not pay in full at the time of service, charges for services in addition to therapy may be levied (i.e.,

involvement in client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept credit or debit cards.

## Insurance

I am aware that if I choose to use my insurance provider, or other third-party payer, an agent of the insurance company may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment. If using an out of network provider, I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed half the amount of the session. I have been given the opportunity to ask questions regarding this statement.

Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. Not all of our clinicians currently directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You are responsible for checking for verification with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Family and Youth Institute, LLC are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e., contacting your primary care physician, insurance company, or a third party "gate keeper." Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

## Court Proceedings

If I ever become involved in a divorce or custody dispute or other legal proceedings, I understand that the therapists at Family and Youth Institute, LLC do not provide evaluations or expert testimony in court. I understand that I should hire a different mental health professional for any evaluations or testimony I require. In the event, my therapist is subpoenaed to appear in court for any reason, I understand that there will be a charge of $1,500.00 per 8-hour day with a minimum of $800 for a half day of 4-hours or less. I understand that a charge of $150 per hour will be collected for each hour over an eight (8) hour day. I understand that a non-refundable retainer of $6,000 must be paid in advance of any court-related work requested including tasks such as report preparation, meetings, interviews, in-court time, phone calls, case preparation, clerical work, file copies, conversations with a court appointed amicus or advocate, and any other tasks related to a court case, and NOT LIMITED, to divorce or custody cases. I understand that the retainer must be paid before any work commences. Cash, cashier checks, PayPal, Zelle, money orders, credit cards, debit cards, or other forms of payment with fund availability verification will be accepted. I understand that because client appointments must be cancelled in advance, payment of fees will be applicable even in the event of court date postponement, rescheduled dates, case dismissal, negotiated settlements, or determination that my services are not needed. I understand that court preparation and clerical time will be charged at a rate of $125.00 per hour to be deducted from the retainer.

Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

# No Surprises Act

*This notice describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.*

You are getting this notice because this provider or facility isn't in your health plan's network and is considered out -of-network. This means the provider or facility does not have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more. If your plan covers the item or service you are getting, federal law protects you from higher bills when:

- You are getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.
- Ask your health care provider or patient advocate if you're not sure if these protections apply to you.
- If you sign this form, be aware that you may pay more because:
    - You are giving up your legal protections from higher bills.
    - You may owe the full costs billed for the items and services you get.
    - Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit.

Contact your health plan for more information. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there is not one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

Prior authorization or other care management limitations. Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage. Understanding your options, you can get the items or services described in this notice from the following providers who are in- network with your health plan:

More information about your rights and protections visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

By signing, I understand that I am giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I am giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on that explained my provider or facility is not in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.

Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

- I fully and completely understand that some or all the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You do not have to sign this form. If you do not sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that is in your health plan's Network.

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate. Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Your estimated out-of-pocket costs are $130 for individual 50 – 55 minute sessions, $155 per couple in 50 – 55 minute sessions or $230 for 70 – 75 minute sessions, and $65 per person in 50 – 55 minute group sessions. Sessions are often weekly, bi-weekly, or as needed. Some relationships benefit from regular sessions together and individually.

A Family and Youth representative has notified me (and/or parent, guardian, or other representative) of the issues above. My signature below shows that I understand and agree with all these statements.

_____ _____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date

Family & Youth Institute, LLC

# Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

## HIPAA Notice of Privacy Practices

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care serves to you, to pay your health care bills, to support the operation of the physician's practice, and by any other use required by law. Treatment: We use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from insurance companies. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In a criminal court proceeding
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may request that any part of your protected health information not be disclosed for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be

disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction with which you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from this office, upon request.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Texas Behavioral Health Executive Council if you believe your privacy rights have been violated by us. You may file a complaint with us by your notification and we will not retaliate against you for filing a complaint. If you have objections to this form, please contact Family and Youth Institute, LLC Management.

## Telehealth Agreement

Telemental health is the delivery of behavioral health services using interactive technologies (use of audio, video, or other electronic communications) between a clinician and a client who are not in the same physical location. The technology Family and Youth institute, LLC uses is Google Meet. It is HIPPA compliant and meets all confidentiality requirements.

I understand the following with respect to telemental health services:

1) I understand that I have the right to withdraw consent at any time.
2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, chances of breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that I am required to maintain privacy and safety on my end of communication, i.e., conducting sessions in a private place, minimizing distractions and interference during session, not engaging in other activities while in session, such as driving, etc.
4) I understand that there will be no recording of any of the online sessions by either party without express, written consent. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written consent, except where the disclosure is permitted and/or required by law.
5) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies.
6) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
7) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, my therapist may end and restart the session. If we are unable to reconnect within ten minutes, my therapist will try to reach me by phone. This call may be from an unknown number.
8) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Family & Youth Institute, LLC

# Family & Youth Institute, LLC

26009 Budde Road, Suite A100
The Woodlands, Texas 77380
Office: 281-748-0233 | Fax: 832-481-6495

Emergency Protocols: My therapist needs to know my location in case of an emergency. I agree to inform the therapist of the address where I am at the beginning of each session. I agree to provide contact with a person whom a therapist may contact on my behalf in a life-threatening emergency.

## Counselor Limits of Confidentiality

All information regarding the specific nature of your counseling or psychotherapy is maintained at Family and Youth Institute, LLC and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use client de-identified specialty consultation with other therapists as deemed necessary. We follow HIPAA and maintain confidentiality.

Your counselor recognizes that confidentiality is essential to effective counseling. For counseling to work best, you must feel safe about sharing your personal information with your counselor. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s)
- If you disclose sexual misconduct by a mental health professional
- To qualified personnel for certain kinds of audits or evaluations
- In legal or regulatory actions against a professional
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations
- Where otherwise legally required
- Insurance providers and other third-party payer are given information that they request regarding services to clients

A court may not consider information that you also share, outside of counseling, willingly and publicly, protected, or confidential. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with your counselor. You may also contact: Enforcement@bhec.texas.gov.

I have read the notices listed above, agree to the above limits of confidentiality, and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18 years old.) Date