LifeSpring
BEHAVIORAL HEALTH
1400 Woodloch Forest Drive, Suite 575, The Woodlands, Tx 77380
Office: 281-528-1523 Fax: 281-719-0491

INFORMED CONSENT & CONFIDENTIALITY

Client Name_____ Date of Birth _____
Address_____
City _____ State _____ Zip _____
Phone #_____ May we text you (SMS)? Y N
Email _____ May we email you? Y N
Emergency Contact_____ Relationship _____
Contact #_____ Do we have consent to contact your Emergency Contact: Y N
Minor's Guardian Information: Guardian's Name _____
Guardian's Contact # _____ Guardian's Relationship _____
Guardian's Relationship (circle one) Single Married Divorced Separated Partners

How did you hear about us? ❑Website ❑Social Media ❑Word of Mouth ❑Doctor ❑Therapist ❑Other:_____

Referred by: _____

OVERVIEW OF THERAPY

I welcome the opportunity to work with you! Legally, this is called "Informed Consent." The information contained here will help you understand better what to expect while working with me as your therapist. Please review the following and feel free to ask questions regarding any items that are unclear to you.

INFORMED CONSENT

CONSENT FOR TREATMENT

- You hereby seek and consent to take part in psychological treatment and authorize me, a therapist of LifeSpring Behavioral Health, to perform initial interview, therapy and/or psychological testing with you.
- You are aware that the practice of psychotherapy or counseling is not an exact science and the predictions of the effects are not precise nor guaranteed. You understand I will work with you as conscientiously and diligently as I can to achieve the best possible results. You acknowledge that no guarantees have been made to you regarding the results of treatment or procedures by this office or me. You understand there are risks and benefits of receiving these services and the risks and benefits of not receiving these services for yourself.
- Further, you understand that evaluation and treatment will involve discussion of personal events in your and/or your family's history which, at times, can be discomforting and very personal. You are aware that you may terminate your treatment any time without consequence. You will remain responsible for payment for services you have received.
- While our sessions might be psychologically intimate, it is important to realize the therapeutic relationship is professional rather than social. Our contact will be limited to the appointments you arrange with me at the office or by telehealth. I cannot attend social gatherings, accept gifts over $50 value, or relate to you in any way other than in the professional context of the therapy sessions. You are best served if the relationship remains strictly professional. Client gain is the most important part of the therapeutic relationship.

By initialing, you agree to all these terms regarding Consent for Treatment: Client Initial _____

BILLING, APPOINTMENTS AND CANCELLATIONS

Fees: INITIAL EVALUATION (75-90 minutes) $160-$275
INDIVIDUAL COUNSELING SESSION (50-60 minutes) $135-$200
GROUP THERAPY (90 minutes) $75-$100

PAYMENT

- Payment is required at the time of service. The practice accepts Visa/MasterCard/Discover/AmEx, cash, check or Venmo. There is a $35 fee for returned checks.
- LifeSpring does not file with insurance. An invoice will be provided after each visit with all the appropriate information necessary for you to file for potential out-of-network benefits if you wish. Existing balances must be paid before further services will be scheduled or provided.
- For missed appointments and those canceled without 24 business hours' notice, you will be billed 50%-100%, depending on the circumstances. If you are late to an appointment by more than 15 minutes, it will be considered a no-show. The session will have to be paid for and rescheduled. Your credit card on file will be charged if you miss the appointment.

By initialing, you agree to and indicate that you understand all these terms regarding Billing, Appointments & Cancellation and Payment: Client Initial_____

CONFIDENTIALITY

- Our work together, our conversations, our records, and any information you provide, is protected by legal privilege. This means the laws protect you from having you or your child's information given to anyone.
- Our practice respects your privacy and we intend to honor your privilege. If you choose to file with your health insurance company, they will likely require a diagnosis to justify payment. Any diagnosis made will become a part of your permanent health record.
- The information you provide in therapy is confidential and will not be shared with anyone without your written consent as prescribed by law. There are a few circumstances when confidentiality, by law, will not be maintained, including the following:
    - Concern of imminent harm to yourself (suicide) or others (homicide)
    - Suspicion of child, elder abuse or neglect
    - Order for release of records by a judge or district attorney
    - Requirement for mental health services from disability, insurance, etc.
    - Sexual exploitation by a previous mental health provider
    - Any other situation required by law
    - If you are under 18, your legal guardian will have access to your records and the ability to authorize release of the information. It is my policy to ask the parent(s) or legal guardian(s) for privileged communication with the child unless I have discussed with the child what information will be shared, imminent danger or abuse are disclosed. When counseling a minor, the focus of therapy will be on healing in the child's life and confidentiality is a key component.
    - Should you need access to your records in the future, please contact LifeSpring Behavioral Health who will retain your records for 7 years (for an adult) or 7 years after your 18th birthday (for a minor).
- In the interest of the client, I may consult confidentially with other professionals within the practice regarding your information to provide the best care possible.

I, _____, give written consent to LifeSpring Behavioral Health to discuss my confidential information with the following people or organizations:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

TELEHEALTH SERVICES

- Telehealth services may be offered if you are interested and I deem this is an appropriate service based on the clinical situation.
- Telehealth services are provided under similar privacy policies as in-person appointments.
- A telehealth session may not be best for everyone and could possibly result in errors in judgment given the restricted information available to me.
- You have the right to stop using telehealth at any time, including in the middle of an appointment, and to request to schedule an in-person appointment.
- You agree to not record any telehealth session without written consent from me, nor will I record any session without your written consent.
- You agree to inform me if any other person can hear or see any part of your session before the session begins, as I will inform you if any other person can hear or see any part of your session.

LITIGATION LIMITATION

Texas law requires that records are maintained each time we meet or communicate. These records will include a synopsis of the therapy session, observations made by me and your treatment plan. Due to the nature of the therapeutic process and it involving making a full disclosure with regard to confidential matters, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf, will ask me to testify in court or any other proceeding, nor will a disclosure of records be requested.

CONTACT BETWEEN SESSIONS OR EMERGENCIES

- For scheduling, please contact me Monday through Friday and I will do my best to return calls within 24 hours or less. For emergencies, please call your local hospital emergency room or 9-1-1.
- The internet is not a totally secure medium for purposes of transmitting counselor-client or other privileged information. If you send messages by email or other electronic form of transmission, you acknowledge and agree you may be compromising confidentiality. If you do correspond with me by email or text, this indicates your consent to receive email or text back from me and therefore I can be held harmless.

  Client initial _____

MAXIMIZING RESULTS

- Please arrive on time for your appointments. This helps me stay on schedule, minimizes wait time and it ensures you receive your full allotted time.
- Success in therapy depends on your desire for change and your willingness to be honest with yourself and with me. Awareness of needs, willingness to feel and to talk about negative emotions, curiosity, and willingness to be challenged will maximize your benefit from our counselor–client relationship.
- We believe that complete healing requires addressing the mind, body, and spirit. Research shows that regular exercise, a healthy diet, and other lifestyle changes improve overall health and quality of life. If you would like, spirituality and prayer can also be a part of your visit. Please let me know if this is your desire.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your initials on this sheet indicate that you have been given the opportunity to request and review a copy of our Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information contained therein, please do not hesitate to contact the office as indicated on your Notice.

Client Initial _____Date_____

Your signature below indicates that you have read, understood, and agree to the above terms:

I request _____ provide professional services to me, _____or to _____, who is my _____. I agree this therapeutic relationship will continue as long as he/she provides services or until I inform him/her that I wish to end therapy.

_____ _____ _____

Signature of Client (or person acting for client) **Printed Name** **Date**

I, _____, have discussed the issues above with the client and/or guardian. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist **Date**

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GRIEVANCE PROCEDURE

Please discuss with me any concerns or complaints you may have as soon as possible so we can work toward a resolution. Expressing anger or disappointment can strengthen our therapist-client relationship. Ethical concerns can be reported to the following organizations:

LCDC
Texas Health and Human Services
Hhs.texas.gov
512-834-6605
PO Box 149347
Mail Code 1979
Austin, TX 78714-9347

LPC or LCSW-S
Texas Behavioral Health Executive Council
Bhec.texas.gov
800-821-3205
333 Guadalupe St.
Tower 3 Room 900
Austin, TX 78701

LifeSpring Behavioral Health Therapists:
J. Chad Anderson, MA, LPC-S
Mark Kakos, LCDC
Michael P. Groves, MA, NCC, LPC
Emily M. Lash, MA, NCC, LPC
Tammy E. Nix, MA, LPC-S, LCDC
Kathryn G. Wainscott, MCMHC, LPC
Nicole V. Garrett, MA, LPC
Brandy M. Hussey, LPC-Associate Supervised by Christie Farris, MA, LMFT, LPC

_____ _____

Client Signature **Date**

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GOOD FAITH ESTIMATE - THERAPY

FOR INFORMATIONAL PURPOSES ONLY. As required by law, this is our notification to you of the possible costs of our services. No action is needed from you. If you have any questions, please contact our office.

Diagnosis: To be determined at initial evaluation

New Patient Evaluation	90791	75-90 minutes	$160-$275/Session
Psychotherapy	90834, 90837	45-60 minutes	$135-$200/Session
Psychotherapy	90832, 90840	30 minutes	$80-$105/Session
Group Therapy	90853	90 minutes	$50-$75/Session
Consultation	99241	50 minutes	$165-$225/Session
Report	99080		$25-$250

Dates of Service: Initial Evaluation and Regularly Scheduled Follow-ups.

Estimated Cost Per Year - $160 - $8000

Tax ID: 93-1774872

Tammy Nix, MA, LPC-S, LCDC	License #71269, NPI #1770965147
Emily Lash, MA, NCC, LPC	License #82306
Michael Groves, MA, NCC, LPC	License #84120, NPI# 1194307595
Kathryn Wainscott, MCMHC, LPC	License #86588, NPI# 1184494999
Nicole Garrett, MA, LPC	License #87835, NPI #1730958695
Chad Anderson, MA, LPC-S	License #63088, NPI #1053624304
Brandy Hussey, LPC-A	License #93512, NPI #1912776279
Mark Kakos, LCDC	License #14548, NPI #1518532597

This Good Faith Estimate (GFE) shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The GFE does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If you are billed for more than this GFE, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the GFE. You can ask them to update the bill to match the GFE, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.