Sarah H. Kramer, Ph.D., LLC

6401 Eldorado Pkwy, Ste 231
McKinney, TX 75070-6199
469/625-1162 Fax: 469/625-1029
drsarah@drsarahkramer.com
www.drsarahkramer.com

CLIENT REGISTRATION

Name: _____ Gender: F M O DOB: _____

Address: _____
Street address City State ZIP

Telephone 1 (belongs to) _____ Telephone 2 (belongs to) _____

Employer (or school): _____ Position (or grade): _____

Email (will not be shared): _____ Physician: _____

Emergency contact: (Name)_____ (Phone)_____ (Rel.)_____

GUARANTOR (PERSON HOLDING INSURANCE)

Name: _____ Gender: F M O DOB: _____

Address (if different): _____

Employer: _____ Guarantor phone: _____

Insurance name, ID and group number (please have card available for copying):

_____

Secondary Insurance (if any): _____

PAYMENT INFORMATION

Please initial in the blanks below to indicate your understanding and agreement:

____ I understand that obtaining pre-certification from my insurance company is my responsibility, though Dr. Kramer's office will provide help whenever possible. I agree to pay all costs that are incurred but not covered by insurance, for whatever reason. Co-pays, deductibles, charges for completing forms, and missed visit or late cancellation fees are my responsibility and are due at the time of the scheduled visit or when services are rendered. **I further understand that, regardless of my expected out-of-pocket costs, I am required to keep a credit or debit card on file, which will be used to pay for any missed visits or late cancellations (less than 24 hours notice).** *This requirement may be waived by Dr. Kramer at her discretion***.** The same card also may be used to pay for my session cost, or I may substitute a different payment method at any appointment.

____ For insurance filing purposes, I hereby assign all medical benefits, including major medical benefits to which I am entitled under private insurance and other health plans, to: Sarah H. Kramer, Ph.D., LLC. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges, *whether or not* paid for by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

My signature below signifies that I have read, understand, and agree to all of the terms above:

Signature *(required)* Date Print Name

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Sarah H. Kramer, Ph.D., LLC

Client Name: _____

CONSENT TO TREATMENT

- **NATURE OF SERVICE**

  I acknowledge that I have received the Informed Consent, HIPAA documents and Information for Parents (if applicable), read them and had any questions fully answered. I hereby consent to engage in treatment provided by Sarah H. Kramer, Ph.D. I understand that I (and my minor child, if applicable) will participate in setting treatment goals and periodically evaluating progress towards them, and that successful therapy requires my/our active participation. I also understand that I may stop treatment at any time, and the only obligation I will have is the payment of any sessions, written materials or missed visits incurred up to that time. The only risk is the loss of potential benefit from therapy. I understand that no guarantees are being made as to outcome or results of treatment, though Dr. Kramer will use her best professional skills on my behalf.

- **MEETINGS, INSURANCE AND CANCELLATION POLICY**

  Therapy sessions occur by appointment on the hour and *last 45-53 minutes*. The fee for the initial visit is $175 and for second and following visits, $150. Different fee schedules may apply if insurance is used. I know that full payment of the copay, deductible or session cost is due at the time of visit. I am aware that Dr. Kramer is an in-network provider for Blue Cross Blue Shield, Tricare, Medicare, Cigna and Aetna and will pre-certify and file these insurance claims on my behalf. I am responsible for any deductible, copays or co-insurance costs and these are due at the time of my visit. I also understand that Dr. Kramer is an out-of-network provider for other insurance plans and that she is happy to provide documentation for visits so that I can file for reimbursement myself.

  I know that I am responsible for scheduling appointments. **If I cancel or reschedule with less than 24 hours' notice, my credit card on file will be charged $60.00. If I no-show for a visit, I will be charged $130.00.** I understand that my insurance company will not be responsible for these charges and they will not be billed to insurance.

- **APPOINTMENT REMINDERS/COMMUNICATION**

  I have read the separate document regarding Dr. Kramer's social media policy and agree to those terms. I am aware that I can call the office and leave a confidential voicemail, use encrypted email via TherapyAppointment.com, or I can send non-emergency texts or leave voice messages at 469-708-2997 **if** I have signed the related consent form. I know Dr. Kramer does not offer emergency services; if I have an emergency, I should go to an Emergency Room or call my physician or psychiatrist. I agree that *even if I do not receive a courtesy reminder, it is my responsibility to attend my appointment* to avoid missed visit charges.

Signature: _____ Printed Name: _____ Date: _____

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CREDIT CARD AUTHORIZATION

I hereby grant Sarah Kramer, Ph.D., LLC authorization to process credit/debit charges.

Client name: _____ DOB: _____

Initial below:

☐ With or without my credit card present, I authorize Sarah H. Kramer, Ph.D. LLC to use the card number provided below to process charges or fees assigned to the client listed above.

☐ I authorize Sarah H. Kramer, Ph.D. to be compensated for any no-shows (not appearing for scheduled visits and not cancelling beforehand) or late cancellations (cancelling or rescheduling less than 24 hours before time of appointment). These charges are not covered by insurance and will not be filed by our office. For missed appointments, a fee of $130 will be charged. For late cancellations, the charge is $65. **After two consecutive missed appointments (no-shows), the client will be considered to have discontinued treatment with Dr. Kramer.**

Please complete all information below:

Type of card (circle) MasterCard VISA Discover AmEx

Cardholder's name _____ (as shown on card)

Card number _____

Expiration date (month/year) _____

Security code (3 or 4 digits) _____

Billing address _____

City _____ State _____ ZIP _____

Authorized signature: _____

Sarah H. Kramer, Ph.D., Licensed Psychologist #31043, Texas

PSYCHOLOGICAL SERVICES—INFORMATION AND AGREEMENT

SECTION 1: BENEFITS AND RISKS OF THERAPY FOR CHILDREN AND ADULTS

Welcome to my practice! I appreciate your choosing to consult with me and hope that our work together will be productive and helpful. Please read each section carefully and be aware that your signature and initials throughout these documents will be requested in order to indicate your understanding and agreement. *Where you see a line in front of text, please initial it.*

Psychotherapy Services: Their Benefits and Risks

I provide individual and family/parent treatment for children 12 and older, adolescents and adults. Your choice of a therapist is very personal and important, and therapy is different for each individual. Research has demonstrated that treatment is most effective when a trusting and positive relationship is formed between the therapist and client, regardless of therapeutic 'technique.' In addition, effectiveness is best when the client and therapist (as well as parents, if applicable) are active partners in the work. I may ask you to complete 'homework' assignments or to practice skills outside the therapy time, to obtain maximal benefits. I use a variety of therapeutic approaches, depending on the needs and abilities of each client. We will work together to develop goals and periodically evaluate progress towards them, revising as needed. Examples of approaches I use include play-type techniques for early adolescents, skill-building and practice, cognitive-behavioral treatment, emotion-focused therapy and others. I attempt to adapt my approach to that which is needed by each client. If your needs are outside my training, I can help you find a different therapist better suited to fulfilling your therapy goals.

Psychotherapy is a journey that can vary in length and approach for different people, or the same person at different times. You may start by talking through current issues, learning new ways of thinking and behaving, and feel satisfied with your progress after only a few sessions. At other times, more long-standing problems will require a longer course of treatment. You may need to confront painful, distressing feelings along the way. Others around you might feel threatened or unsettled by changes you are demonstrating. The ultimate benefits of therapy for most people have been shown by research, and most clients find these challenges well worth the risks.

_____ If you have questions, or are not comfortable with any aspect of your therapy, please discuss it with me. Though I will use my professional skills and knowledge to the best of my abilities, I cannot guarantee that treatment will be effective.

_____ If you are a parent, please refer to the separate document on therapy for children and adolescents for specific comments and information about the treatment of minors. The more closely we all work together, committed to and communicating with each other about the issues, the better the outcome is likely to be.

Section 2: Appointment Times, Cancellation Policy, Social Media Policy

Meetings

_____ Appointments are scheduled to begin on the hour and last 45-53 minutes. (At least 5 additional minutes will be used for documentation after you leave.) If you arrive late, your session cannot be extended, since this would intrude on the next client's time. You may request that someone else attend a therapy session with you, but please discuss this with me in advance. I typically see clients weekly or every other week for best results, but this can be adapted to your budget and schedule.

_____ Because your appointment time is reserved specifically for you, if you cancel with less than 24 hours' notice, you will be charged $65 for that session. If you do not show up at all for your appointment, your credit card will be charged $130. These charges cannot be billed to your insurance. Exceptions to this rule are very limited and will be handled on a case-by-case basis.

Contacting Me

Because of my work schedule, I am often not immediately available by telephone. I do not answer calls during appointments, so please leave a message, including your telephone number. My current office hours vary, but you may leave me a confidential voicemail at the office number (469-625-1162). I try to return all calls within one business day, but sometimes it may be longer. Issues for *established clients*, such as paying a bill, appointment changes, or cancellations can be managed by logging onto TherapyAppointment.com with your unique password, or by calling my assistant, Judy Moubray, at 940-782-9827.

_____ The use of TherapyAppointment.com is strongly encouraged if you wish to e-mail me, as their e-mail is encrypted. Email is generally not suitable for client communication of sensitive issues due to privacy concerns. However, if you wish to send documents via attachment, they must be sent to DrSarah@drsarahkramer.com. Please do not use e-mail for emergency contacts. I will not discuss therapy issues with you via e-mail due to privacy issues and professional standards; please raise these points during your session.

_____ **If you feel you are having a crisis**, please call 911, go to the nearest Emergency Room, call your medical doctor or psychiatrist, or call the Suicide and Crisis Center of North Texas Hotline at 214-828-1000. I am not equipped to provide crisis services.

Social Media Policy

I maintain a website for this practice (http://www.drsarahkramer.com). There, you can learn more about my training and experience, download these documents, view a map to the office, and utilize a link to TherapyAppointment.com for email and scheduling.

_____ Although I also have a Facebook page for this practice (www.Facebook.com/drsarahkramer/), in order to maintain therapeutic boundaries I will not 'friend' any client or their family member(s) on Facebook or connect with you on LinkedIn, Google+, Instagram or similar sites. Please keep in mind that if you choose to communicate with me online, you may inadvertently be disclosing to others that you are (or were) my client. I rarely text with clients because your privacy cannot be guaranteed through this medium. However, if you sign the Texting Release Form on my website, we can exchange brief, non-clinical texts about your arrival, getting directions to the office and the like.

_____ Please be aware that psychologists cannot comment on content in rating sites such as HealthGrades.com or Facebook, and ratings that others leave may, or may not, accurately reflect their true experiences. In addition, I will not 'follow' you or search online for your information unless you request that I view a specific site, e.g. your poetry or art online.

Section 3: Fees, Other Charges, Insurance, Payments, and Credit Card Policy

Fees and Charges

_____ My fee for a 50 to 53-minute appointment is currently $175.00 for the first visit and $150.00 thereafter. If you are using insurance, the charges will be lower and will reflect the agreement I have with your insurance company, as well as your individual policy. You cannot be charged for the difference as long as I am an in-network provider. Some policies may require only a 45-minute session.

_____ Your payment or copayment must be collected at the time of your visit, by law. I normally do not charge for brief (8 minutes or less) telephone contacts between appointments, unless they become frequent or long. You will be charged on a pro-rated basis for any professional activities, such as filling out forms, writing letters, or treatment summaries. If paying for therapy becomes a problem for you, I will be happy to assist you in locating more affordable treatment, or possibly work out a payment plan under specific circumstances.

_____ I accept cash, check or credit cards for payment. (If a check is returned, there will be a $35.00 fee.) I also require that you place a valid credit or debit card on file with me. This card will be used to charge for any missed visits that are not cancelled or paid for some other way. *Please sign the separate credit card agreement in these documents.*

_____ I reserve the right to use legal means to secure payment, including the use of a collection agency for unpaid balances after 90 days. Only the minimum amount of information required would be given to such an agency. *Your signature below authorizes such action.*

_____ Because therapy is based on mutual trust and privacy, I request that you not involve me in any legal proceedings or request therapy records for legal purposes. If a judge requires my participation, there is a separate (higher) set of charges and a written agreement which will be furnished to you and your attorney.

Insurance and Billing

I participate in a number of managed care plans and am currently in-network for:

- Blue Cross/Blue Shield PPO plans, including out of state
- Cigna
- Aetna
- Tricare/Value Options
- United Healthcare
- Medicare (traditional and Aetna)

For all other insurance companies, I am considered “out of network,” meaning there is a higher copayment or coinsurance expected from you. In that case, you are entitled to see in-network providers for a lesser payment if you wish; please consult your insurance company for their names. For any insurance that I accept, I will use electronic billing and you will only be responsible for the deductible and copay. For all others, the full fee will be collected at the time of the visit. I am happy to provide you with a ‘superbill’ which you can often use to obtain out-of-network benefits, usually 40-60% of their

allowable amount for that service. It is recommended that you call your insurance company in advance to determine their policies and what your costs would be.

You should also be aware that most insurance companies require you to allow me to provide them with a clinical diagnosis and dates of service. Sometimes I have to provide other information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will undoubtedly be stored electronically. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will notify you if an unusual amount or type of information is requested; you do have the option of paying the fee yourself to protect the patient's privacy.

Section 4: Confidentiality and Records

Confidentiality and Record-Keeping

_____ Your therapeutic documentation is considered legally 'privileged' information, which I will do my utmost to protect. Your records include the registration pages you completed and signed, your insurance information and filing history (if you use insurance), the history and current symptoms of the client, dates of treatment, along with ongoing symptoms, treatment goals and treatments given. They will also include any reports that have been generated, correspondence, and treatment records I may have received from others. If testing is involved, the actual test data are protected from release according to Texas law, unless they are sent directly to a qualified mental health professional. For specific questions about how to access your records, please refer to the separate HIPAA notice, available on my website or by request in paper form.

_____ **There is a limited number of situations in which I am required by law to compromise confidentiality to protect the client or others from harm**. These include:

- imminent threats to the safety of the client or specific other persons
- sexual, emotional or physical abuse of a child, adult 65 years or older, or an adult with disabilities (including financial exploitation of elders)
- if an adult patient experienced childhood abuse or neglect, and I believe in good faith that the health and safety of another child, elder or disabled adult may currently be endangered
- exploitation or abuse of a client by any mental health professionals
- court actions (court order, grand jury request, legal actions affecting parent-child relationship, etc.), including if you bring suit against me
- These (and a few other) exceptions to confidentiality are very important! I strongly recommend that you carefully read the accompanying HIPAA information and ask questions about *any* issues about which you have concern.

_____ It is important for you to know that according to the American Psychological Association and State of Texas ethical requirements, and to provide the best care, I will maintain professional boundaries with you. For example, I will not greet you in public if we happen to see each other (unless initiated by you). I can only serve as your therapist and will not be a friend, pursue sexual or romantic intimacy, or conduct other business with you (e.g., if you are a computer consultant, I cannot utilize your professional services and have a therapy relationship with you). Psychologists cannot employ or trade services with their clients.

Complaint Procedures

As mentioned previously, if you have any concerns, complaints or worries about our work together (or mine with your child), *please raise them with me*. I will make every effort to address them openly and fairly. If you feel that I have treated you unfairly or broken a professional rule, please tell me. If you are not satisfied with my services, I can assist you in finding another provider, if you wish. Should you believe I have behaved unethically, you have the right to file a complaint with the Texas State Board of Examiners of Psychologists, 333 Guadalupe, Suite 2-450, Austin, TX 78701.

My signature below indicates that I have read and understand the nature of the psychological services, office policies and procedures, and my legal rights, and agree to the conditions above.

Signature _____ Date _____

Printed Name _____

Name of patient, if signed by parent or guardian: _____

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TEXAS HIPAA NOTICE FORM

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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY. THIS INFORMATION IS BEING PROVIDED TO YOU AS REQUIRED BY LAW.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

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

- "PHI" refers to information in your health records that could personally identify you.
- "Treatment" is when I provided, coordinate, or manage your health care and other services related to your health care. This includes mental health care. An example of treatment would be speaking to your primary care physician, another psychologist or psychiatrist about your therapy.
- "Payment" is when I obtain reimbursement for your therapy. For example, disclosing your PHI to your health insurer to obtain reimbursement for your care or to determine eligibility or coverage.
- "Health care operations" are activities that relate to the performance and operation of my practice. Examples include business related matters such as audits or administrative services, quality assessment, or case management.
- "Use" applies only to activities within my office, such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside my office, such as releasing, transferring, or providing access to information about you to other parties or providers.
- "Authorization" is your written permission to transfer information to another health provider or entity. All authorizations must be completed on a legally-defined form.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations only when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this data. I would also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a therapy session or telephone call, or joint therapy session, which I have kept separate from the rest of your medical record. I may not always keep such notes, but they are given a greater degree of protection than is your PHI.

You may revoke at any time any authorization of PHI or psychotherapy notes that you have made previously, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained it as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

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

- **Child Abuse**: if I have cause to believe that a child under age 18 has been, or may be, abused, neglected, or sexually abused, I must report this within 48 hours to the Texas Dept of Protective and Regulatory Services, or to any state or local law enforcement agency. Also, a 2013 law enacted by the Texas legislature requires that if I have cause to believe you were abused or neglected as a minor by an individual who is still living, I must make a similar report, if needed to protect the health and safety of a minor child or elderly or disabled person.
- **Adult and Domestic Abuse**: if I have cause to believe that an adult over age 65 or disabled person is being abused, neglected, or financially exploited, I must report this to the Department of Protective and Regulatory Services.
- **Sexual Abuse by a Mental Health Professional**: if you disclose to me that you have previously been the victim of sexual exploitation and/or abuse by a mental health professional in Texas, I am required to notify the district attorney's office in the county in which the abuse took place, as well as the licensing board that has authority over that mental health professional.
- **Serious Threat to Health or Safety:** if you have made a specific threat of violence against someone else or if I believe that you present a risk of serious, imminent harm towards another person, I may have to disclose confidential information in order to ensure their safety. This may include involving law enforcement or seeking your hospitalization.
    - Similarly, if I have reason to believe that there is a probability of clear, imminent physical or mental injury or death towards yourself, I am obligated to disclose relevant confidential mental health information to protect you.
- **Worker's Compensation**: if you file a workers' compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier, to the extent required by law.
- **Other**: there are other exceptions to confidentiality defined by law, including disclosing your PHI for health and oversight activities, judicial or administrative proceedings, billing activities, legal and professional defense, professional consultation, and others. This also includes having another designated psychologist handle your therapy records and PHI in the event of my unexpected death or disability.

PATIENT'S RIGHTS AND PSYCHOLOGIST'S DUTIES

Patient's Rights:

- 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.
- You have the right to request and receive confidential communications of PHI in different ways and places from your main contact information. For example, if you do not want correspondence from me mailed to your home, you may request that it be sent to a different address, e.g. your office.
- You may inspect and/or obtain a copy of PHI (and psychotherapy notes, if available) from my mental health and billing records, as long as the PHI is maintained in the record. I may deny your request under certain circumstances, but you may have this decision reviewed. (The primary reason for denial of this request would be concern that information included in PHI may cause serious harm to you.) You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so that you can discuss the contents. There is a charge of 25 cents per page for copying/printing records, though I do not charge for sending them to another health provider.
- You may request an amendment (change) of PHI for as long as the PHI is maintained in the record, which is a period required by state law. I may deny this request. In that case, you have the right to

file a letter of disagreement with this practice at the address above. Upon receipt of such a letter, I may prepare a rebuttal to your statement and provide you with a written copy. Upon your request, I will discuss the details of the amendment process with you.

- Generally, you have a right to receive a listing of disclosures of PHI for which you have neither authorized nor consented. On your request, I will discuss the details of this with you.
- You have the right, upon your request, to have a paper copy of these guidelines given to you even if you have agreed to receive the notice electronically.
- You have the right to be notified if there is a breach (use/disclosure of your PHI in violation of the HIPAA Privacy Rule) of your PHI; if your PHI has not been encrypted to government standards; or if my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with this notice of my legal duties and privacy practices with regard to your PHI.
- I reserve the right to change these policies and practices as described in this notice. Unless I notify you of such changes, thought, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by posting it on my website, making it available in my office, or giving it to you in person and/or by mail.

QUESTIONS AND COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please discuss these concerns with me.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

This notice is effective January 1, 2019. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by making it available on my website and at my office at your next visit.