Peltier Family Counseling, PLLC

Mariah Peltier, LPC
1333 W. McDermott Dr., Ste. 150
Allen, TX 75013
(974) 447-8280

Patient Information

Patient Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell: _____ Work #: _____
Social Security Number: _____ DOB: _____
Age: _____ School: _____ Grade: _____
Occupation: _____ Employer: _____
How did you hear about us? _____

Parent or Spouse Information

Mother/Wife: _____ DOB: _____
Address (if different) _____
City, State, Zip _____
Home #: _____ Cell: _____ Work #: _____
Occupation: _____ Employer: _____

Father/Husband: _____ DOB: _____
Address (if different) _____
City, State, Zip _____
Home #: _____ Cell: _____ Work #: _____
Occupation: _____ Employer: _____

Children's Information

Name: _____ Age: _____ School: _____ Grade: _____
Name: _____ Age: _____ School: _____ Grade: _____
Name: _____ Age: _____ School: _____ Grade: _____
Name: _____ Age: _____ School: _____ Grade: _____

Primary Care Physician: _____ **Phone:** _____
Pediatrician: _____ **Phone:** _____
OB/GYN: _____ **Phone:** _____
Current Medications/Vitamins: _____
Presenting Problem: _____
Emergency Contact: _____ **Phone:** _____

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Financial Agreement

Financially Responsible Person:
Name**:** _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell: _____ Work #: _____
Relationship to Patient: _____

I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Peltier Family Counseling. If Mariah Peltier, LPC, is contracted with my insurance, I will be responsible for co-payment, deductible, and non-covered services as determined by the insurance plan.

Signature: _____ *Date:* _____

Complete the following if Mariah Peltier, LPC is contracted with your insurance company:

Insurance Company Name: _____
Phone number: _____
Address to File Claims: _____
Subscriber's Name: _____
Relationship to Client: _____
Employer: _____ DOB: _____ SSN: _____
Member ID number: _____ Group ID #: _____

I authorize and request my insurance to pay directly to Peltier Family Counseling, the amount due for services rendered to me or my dependent. I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. This consent is subject to state and federal confidentiality requirements.

Client or Guardian Signature: _____ *Date:* _____

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Contact Agreement

We request the information below so that we are better able to protect your privacy and ensure the best possible service. Please note that we may contact you or your insurance company in regards to your appointments or private information. Please indicate whether or not you authorize us to contact you at the following locations:

I authorize that messages may be left for me or calls may be returned to my:
Home #: _____ Cell #: _____ Work #: _____

I authorize that I may receive written communication to my:
Fax: _____

I acknowledge that Mariah Peltier, LPC, may use electronic forms of communication, including fax and cellular phones, as a means of communication and cannot guarantee the security of these forms of communication. I acknowledge and authorize that another person may answer my phone and give permission for Mariah Peltier, LPC to leave information with that person.

Client or Guardian Signature: _____ *Date:* _____

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NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. If you have questions about this notice, please contact Mariah Peltier, LPC, at the number at the top of this form.

Beginning April 14, 2003, the law requires that you be given a copy of this Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you have access to it. We are required to abide by the terms of the notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a revised Notice at any time.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions you may have.

You have the right to receive, and we are required to provide you with, a copy of this Notice. We are required to follow the terms of this notice.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing. However, this will not affect any use or disclosure made by us prior to the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy of a claim under the policy even if you revoke the authorization.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request, particularly with regards to raw testing data.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information. You must submit sufficient information to support your request, and your request must be made in writing.

You have the right to complain to us about our privacy practices. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

You have the right to receive confidential communications from us.

How We May Use or Disclose Protected Health Information
Following are examples of use and disclosures of your protected health care information that we are permitted to make.

For Treatment - We may 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 of your health care with a third party that is involved in your care and treatment.

For Payment -Your protected health information will be used, as needed, to obtain payment for health care services.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices.

Other Permitted and Required Uses and Disclosures
There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our best professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations. We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare – With your written permission, we may disclose to a person you choose your protected health information that directly relates to that person's involvement in your health care.

For Legal Proceedings – We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by the court.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits and investigations of possible health fraud. This also includes disclosing inappropriate conduct made by another health care provider, such as sexual contact made by another mental health provider.

In Cases of Abuse or Neglect—It is a state law that anyone who suspects abuse or neglect of a child or elderly person must report it to the appropriate regulatory agency within 48 hours.

In Case of Serious Threats to Safety – We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public.

Please sign below indicating that you have read the terms of this Agreement.

_____	_____	_____
Date	Patient Signature (parent if under 18)	Name of Person Signing
	_____	_____
	Patient Name	Relationship to Patient

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Court Services Letter of Agreement

I hereby acknowledge that I have received the outline of fees for the court related services of Mariah Peltier, LPC of Peltier Family Counseling, PLLC. I also understand that I agreed to the responsibility of court related fees when I signed the initial letter of agreement for services. I understand that these terms are applicable both while I am receiving services and following termination.

FEES FOR COURT-RELATED SERVICES:

Phone Consultations with attorneys, judges, family court counselors, district attorneys: $150 per hour, quarter hour minimum.

Reports for court, attorneys: $150 per hour.

Court deposition appearance or court appearance: $300 per hour for time spent both in-route and on-site; 4 hour minimum charge (must be paid in advance).

Additional out of town charges: reimbursement of actual out-of-pocket travel expenses to include mileage, and/or transportation costs, toll and parking fees, meals, and lodging.

Copies of client file: $50 minimum charge (must be paid in advance).

OTHER REQUIREMENTS:

Release: Patients must sign a Release of Information form allowing Peltier Family Counseling, PLLC to openly communicate with all parties related to the lawsuit. For the safety and professionalism of the counseling process, no exceptions will be given.

Subpoena: A subpoena must be issued before Peltier Family Counseling, PLLC can make a court appearance, deposition appearance, or deliver records. Party issuing subpoena will be financially responsible for all related fees (see above charges).

Payment of Fees: All fees for records, court and deposition appearances must be paid in advance. A half day (4 hour) minimum must be paid for court appearances and/or deposition appearances.

_____	_____		
Patient Signature (Parent if under 18)	Name of Person Signing		
_____	_____	_____	
Patient Name	Relationship to Patient	Date	

Peltier Family Counseling, PLLC

Mariah Peltier, M.Ed., LPC

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Phone: (972) 447-8280

Information and Consent for Treatment

This document sets forth the business terms of the engagement between you (the patient) and Peltier Family Counseling and has been prepared for you in order to allow the maximum use of the session time. Please read this carefully and feel free to ask questions before signing.

Scope of Services: You are engaging in a therapeutic counseling relationship that is of a professional nature. As a therapist, I believe that all people have the capacity for growth and change in their lives, and therapy is designed to help make those changes a reality. I strive to create an environment of safety and trust in order to facilitate healing and growth. I am trained in a variety of counseling needs for all ages. These issues include depression, anxiety, bipolar and other mood disorders, borderline personality disorder, relationship issues, women's issues, codependency, eating disorders, self-mutilation (cutting, burning self, etc.), ADD/ADHD, and behavioral problems. In working with children, I am trained in both child-centered play therapy and in interactive skills training and behavioral development. I am also trained in various trauma recovery issues, including working with adult trauma survivors in overcoming childhood physical, verbal, emotional, and/or sexual abuse. My trauma training also includes working with recovery needs resulting from the devastation of recent hurricanes. Finally, I am trained in faith-based counseling. If this is something that you are interested in pursuing further as a part of your treatment, please ask me about it and we will discuss it in more detail. If at any point you or I determine that a referral is needed, I will provide you with referrals and/or resources to assist you. You will be responsible for contacting and evaluating these resources.

The Role of the Client: While I, as the therapist, am committed to providing you the best possible psychological treatment and care, I view my relationship with my clients as a collaborative approach. Your active participation is essential in order to achieve the maximum benefits of counseling. This includes keeping your appointments, completing your homework assignments, and being willing to apply what you have learned in therapy into your daily living. As your therapist, I also have the right and responsibility to discontinue therapy with you if I see that counseling is doing you harm. I will discuss this with you as needed in order to provide the best outcome possible for you. You also have the right to discontinue therapy at any time. I do request that you discuss this with me prior to discontinuing therapy, and I usually will recommend a termination session in order to provide closure and any necessary referrals. My goal is to provide the best possible service to you, and your honest feedback is important in making that happen.

Effects of Therapy: Counseling has both benefits and risks. Therapy is designed to provide such things as solutions to problems in your life; decreased pain and distress; improved mood and coping abilities; healing from trauma and pain; improved relationships; and emotional freedom. In this process, emotional pain is often a reality. Sometimes symptoms will appear to worsen prior to improving, and it is important to remember that there are no guarantees that counseling will work for everyone. We will discuss the results you want to achieve in counseling, as well as the possible risks and outcomes, in order to help you reach your therapeutic goals in the best possible manner.

Therapeutic Relationship: Your sessions with me will often involve your personal vulnerability. Because of this, it is important to remember that our relationship is a professional relationship rather than a personal or social relationship. This is for your own protection and good, as it maintains your confidentiality and allows for you to receive the maximum benefit from the therapeutic process. In order to protect your confidentiality, if you and I see each other in public, I will not acknowledge that I know you, unless you initiate communication with me. Our contact will be limited to scheduled appointment times. In the event of a life-threatening emergency, you will be directed to call 911 or go to an emergency. If necessary, crisis consultation can occur by phone to provide stabilization until we can meet for another scheduled appointment. **Please remember that insurance typically does not reimburse for phone counseling and that you will be responsible for any fees incurred for phone counseling or crisis consultation.**

Appointments: Appointments are typically scheduled for 45-50 minutes, although longer sessions can be arranged as deemed necessary. I generally meet with clients weekly when beginning treatment and, as therapy progresses, begin to meet less frequently. In order to best serve all of my clients, please make every effort to arrive on time for your appointment. If you arrive late, you will receive the remainder of your scheduled appointment time if it is within 15 minutes of your scheduled time due to insurance regulations. A 24-hour notification is required for all cancelled appointments, except in cases that I determine to be an emergency. If a 24-hour notification is not given, a $50 fee will be charged. Insurance companies will typically not pay for this fee, so it will become your personal responsibility. Phone or video sessions are also available, but they are not covered by most insurance companies.

Confidentiality and Records: All communication between is part of your clinical record with me. This will be kept in the strictest confidence and you can expect your records to be secure, private, and confidential both during the period we meet for counseling and for the required time I am legally bound to maintain your records. I will not disclose any non-public information about you except as permitted by law, or as authorized by you. You authorize Mariah Peltier, LPC to release your confidential information to (i) your parent or guardian; (ii) other professionals, including your attending physicians; (iii) to others if required to disclose by law; (iv) to a third party if I believe that you are in immediate danger of harming yourself or someone else; (v) to a third party payer if that party is paying or reimbursing for my services; and (vi) to other employees in our office who need to know the information in order for us to work with you.

Fees and Payment: Initial assessments are one-hour appointments and are a fee of $150. The fee for a 45-50 minute individual, couples, or family session is $120. Fees for longer sessions will be charged in 15 minute increments. There are additional fees for the copying of records, for any additional administrative services provided outside of a standard appointment, or for any services provided regarding legal proceedings. The specifics of any of these charges can be discussed with me. Payment is due at each session and is accepted by cash, check, or credit card. Checks should be made out to Peltier Family Counseling. I will not accept post-dated checks or bartering of services. There is a $25 fee for checks returned for non-sufficient funds. If you maintain a past-due balance, you will not be able to schedule another appointment until you pay this balance.

If I am an in-network provider with your insurance company, you will be responsible for payment of your co-payment, deductible, and non-covered services, and I will file a claim with your insurance company as a service to you. Please consult your insurance plan for the terms of your eligibility, your benefits, and your reimbursement procedures. I will also verify your eligibility and benefits, but it is ultimately your responsibility to know what your coverage, benefits, and exclusions.. Please remember that while insurance companies quote benefits, these quotes are not a guarantee of payment, and you will be responsible for any charges the insurance company does not cover. If I am not an in-network provider with your insurance company and you wish to file an out-of-network claim with them, you will be responsible for payment to me and I will provide you with the necessary paperwork to file with your insurance company for reimbursement.

Contact and Emergencies: You may contact me by phone at (972) 447-8280 to schedule or cancel an appointment, or if additional communication with me is necessary. In the case of a life-threatening emergency, please go to your nearest emergency room or call 911. If you are unable to reach me in a timely manner, you should contact your physician, a local emergency room, or contact 911.

Complaints: I am licensed by the Texas Board of Examiners of Licensed Professional Counselors, license #59950. My services will be provided in a professional manner consistent with the legal and ethical standards established by the Texas Board of Examiners of Licensed Professional Counselors. You have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, me, or any policies, please bring it to my attention so it can be resolved as quickly as possible. If a complaint is not resolved, the Texas Board of Examiners of Licensed Professional Counselors can be reached at 1-800-942-5540.

Please sign below that you have read and understood all of the above information. You may receive a copy of the above information at your request. Signing indicates that you are consenting to receive treatment from Mariah Peltier, LPC. You may revoke this agreement in writing at anytime. I understand that if Mariah Peltier, LPC, is unavailable (on vacation, for example) this consent is transferable to another designated professional covering for Mariah Peltier, LPC.

Client or Guardian Signature: _____

Printed Name: _____ **Date:** _____