LEVY
PSYCHOLOGICAL
ASSOCIATES

9701 Brodie Lane Suite #205
Austin, Tx 78748
admin@levypsych.com
512-420-8444

Consent and Services Agreement

Welcome to your first session at Levy Psychological Associates! Please review this form carefully, and feel free to ask us any questions!

About our Services:

It's our goal to offer a positive, empowering, and life-enriching experience for our clients. The potential benefits of counseling are many and include improved functioning, relationships, self-image, mood, and the attainment of personal goals. However, in some cases persons have reported feeling worse after counseling. Clients understand that healing and growth is difficult, and some discomfort will likely be a part of the counseling process.

Confidentiality:

Your confidentiality and privacy is extremely important to us. Levy Psychological Associates is considered a "covered entity" under HIPAA, meaning that we comply with HIPAA privacy rules. All communications and records with your counselor are held in strict confidence. Information may be released, in accordance with state law, when (1) the client signs a written consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) for billing purposes; or (5) a subpoena or court order is received. In compliance with ethical codes, including section 2.2 of the AAMFT Code of Ethics, when providing couple, family, or group treatment, your counselor will not disclose information outside the treatment context without a written authorization from each individual competent to execute a release. The client agrees to this policy regardless of who is paying for services, and regardless of who is listed as the 'identified patient' for 3rd party payments.

Electronic Communication & Online Counseling:

Telephone, email, and videoconference are not encrypted methods of communication, and some confidentiality risk exists with their use. Our team communicates using these mediums. Occasionally, your counselor, or someone from our team, may follow up with you by telephone or email for scheduling, billing, quality assurance, or other issues. If you would prefer not to be contacted by email, simply inform your counselor and your preferences will be respected. If you and your counselor are participating in distance counseling sessions the counselor will abide by the laws and ethical codes of his/her state of licensure. While a growing base of research has shown that distance counseling services—through various electronic means—can be effective, such services are relatively new in comparison to traditional (in-person) counseling, which has a much longer track record of positive outcomes. Distance counseling may not be appropriate for some clients and for the treatment of some mental health issues.

Conflicts:

We work hard to ensure that you have a positive experience. However, if a conflict occurs, it is agreed that any disputes shall be negotiated directly between the parties. If these negotiations are not satisfactory, then the parties agree to mediate any differences. Litigation shall be considered only if these methods are given a good faith effort.

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Emergency Contacts:

Your counselor will establish emergency contacts for you, such as a family member, a mobile phone, or work phone number. These contacts may be used if your counselor perceives a need. If you are in crisis and cannot reach your counselor, please go to your nearest emergency room or call 9-1-1.

Scheduling and Cancellations:

Appointments can be cancelled/rescheduled with at least 24 hours notice provided. If you provide less than 24 hours, the client agrees to pay a no show/late cancellation fee of $99 (insurance will not pay for missed appointments). For appointments that are scheduled for a Sunday or Monday, you will need to notify the office by 5:00 pm on Friday in order to cancel or change the appointment, to avoid the $99 fee. For your convenience, our phones are answered Monday – Friday from 9:00 am to 5:00 pm. Please note that we do enforce this policy. By initialing here _____ you are agreeing that we can charge your credit card on file for any missed session fee.

Service Fees:

Payment, including insurance co-pays, is due at the time of the service. Client gives the practice permission to charge their credit/debit card on file for any outstanding fees. To change payment method simply call our office or email admin@levypsych.com

Clients understand they are fully responsible for all session fees even if insurance or other vendor does not pay for any reason.

If my account becomes delinquent, and is assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement.

I have been provided a Notice of Privacy Practices and I have also read and fully understand and agree to honor this agreement. I consent to a comprehensive initial assessment which will result in an individualized treatment plan. I consent to treatment and understand that I have the right to refuse and or halt treatment at any time.

Client(s) Signature: _____ Date: _____

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Client Information Sheet

I am required to collect some of the following information due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. For more information on this act and how you and your Protected Health Information (PHI) are affected, see my Notice of Privacy Practices on the following page.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Alternate Phone: _____

Occupation: _____ Employer: _____

Sex: _____ DOB: _____ Marital Status: _____ Ethnicity: _____

Insurance Information

Name of Insured: _____ Rel. to Patient: _____

ID#: _____ Social Security#: _____

DOB: _____ Phone #: _____ Group #: _____

Health Concern(s)

List of any drugs/medications you currently use: _____

Emergency Contact Information

Name: _____ Relationship: _____

Mobile Phone: _____ Alternate Phone: _____

Please describe the concern(s) which bring you here: _____

_____

Assignment of Benefits/Release of Information/Co-payments: I agree to contract with Levy Psychological Associates for an initial session only. At that time, we will jointly determine the appropriateness of continuing the therapeutic relationship. If we decide to continue, at that point this document will remain valid.

I hereby authorize Levy Psychological Associates to release any information deemed necessary by my insurance carrier for the processing of my claim and/or certification of care provided. I authorized Levy Psychological Associates to receive payment directly on any medical benefits otherwise payable to me for services as described on the attached claim form not to exceed the reasonable and customary charge for those services. I am aware that any co-payment or deductible due by me is to be made at the time of the visit. If I am not the insured/responsible party, i authorized Levy Psychological Associates to exchange information with the insured responsible party for billing purposes only.

Patient/Guardian Signature: _____ Date: _____