# New Patient Information

***Confidential***

Date:________________

Patient Name:______________________________ SSN:_____-_____-______
Last First M.I.

Address:__________________________________________________

City:__________________________ State:__________ Zip:____________

Home Phone:(___)_____-________ Work Phone:(___)_____-__________ Ext:________

Cell Phone: (___)_____-________ E-mail: ____________________________

Is it OK to call and leave a message at these numbers: ☐ yes ☐ no

Gender: [ ] Male [ ] Female Date of Birth:______-_______-________ Age:_______

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] NA (child)

Employment Status:[ ] Employed [ ] Student [ ] Disabled [ ] Employed/student [ ] Unemployed

Employer (or) School:____________________________________________

Insurance Company:____________________ID #_________________________

Referral Source:_____________________________________________

Permission to thank referral source? (circle one): Yes or No

Referral Type: [ ] self [ ] family [ ] spouse [ ] friend [ ] physician [ ] EAP [ ] work
[ ] court [ ] school [ ] internet [ ] other ____________________

Primary Care Physician: ________________________ Phone:____________

Permission to communicate with PCP about your treatment? (circle one): Yes or No

In Case of Emergency, Contact:

Name:________________________ Relationship:____________________

Phone:________________________

For children & adolescents:

Parents marital status: ☐never married ☐married ☐separated ☐divorced ☐widowed

| | [ ] Mother (or Guardian) | [ ] Father |
|---|---|---|
| Name: | | |
| Address: | | |
| | | |
| | | |
| (H) Phone: | | |
| *(W) Phone:* | | |

Custody Arrangement (for divorced/separated parents):
☐informal (no court order) ☐ joint legal custody ☐ sole legal custody (mother)
☐ sole legal custody (father) ☐ other:______________________
Primary residence of child is with: ______________________

Anne Manske, MA-MFT, LPC
Phone: (210) 542-6162 Fax: (210) 201-8186

# NOTICE: LATE CANCELLATION & NO-SHOW FEE

## EFFECTIVE JANUARY 2, 2014

Please note that our office will now be enforcing our No Show/Late Cancellation Fee beginning January 2, 2014, which includes the following:

- If you DO NOT SHOW for your scheduled appointment you will be charged the full session fee of $95.00.
- If you DO NOT CANCEL 24 HOURS PRIOR to your scheduled appointment you will be charged a 95.00fee.
- This fee must be paid prior to your next appointment being scheduled.
- Future appointments scheduled in advanced will be cancelled if the $95.00 fee is not paid by the same day the original no-show or late rescheduled appointment was scheduled.

I have read, understand, and have been advised concerning the contents of this document, and have received a copy of this entire document.

______________________________

Patient's Name (Please Print)

______________________________ ____________________

Patient's/Parent's or Legal Guardian's Signature Date

______________________________ ____________________

Anne Manske, MA-MFT, LPC, LMHC Date

# ~ Anne Manske, MA-MFT, LPC ~

## REQUEST FOR PROFESSIONAL SERVICES/CONSENT FOR TREATMENT

**This document ("agreement") contains important information about the services offered to individuals and outlines the policies and procedures that underlie the delivery of those services. This document also contains a summary of the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that took effect on April 14, 2003. HIPPA provides new privacy protections and patient rights with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment for services, and health care operations.**

### ABOUT THE THERAPIST/COUNSELOR

Anne Manske is a Licensed Professional Counselors (LPCs) who hold a Master's degree or higher in Counseling. My Master's Degree is in Marriage and Family Therapy from St. Mary's University in San Antonio.

### CONTACTING THE COUNSELOR

Our office is typically open Monday – Friday from 10:00am - 6:00pm and we are only available by appointment only. Evening and Saturday appointments are available by appointment only with available counselors. When your counselor is unavailable, messages can be left on our confidential voicemail at 210-542-6162. Generally, calls are returned within twenty-four hours, with the exception of weekends and holidays. If it is difficult to be reached, patients should leave times they would like to be contacted by the counselor. In emergency situations when it is difficult to wait for a return call from the counselor, patients should contact their family physician, the nearest emergency room, or dial 911 and ask for the psychologist and/or psychiatrist on call.

### BENEFITS AND RISKS OF COUNSELING

One major benefit that may be gained from participating in counseling is the resolution of the concerns that originally brought you to counseling. Other possible benefits may include a better ability to cope with family and other interpersonal relationships, and/or a greater understanding of personal goals and values.

However, during therapy you may experience discomfort, such as anger, depression, or frustration as you resolve concerns. Also, concerns may arise between family member(s) and other person(s) that can lead to discomfort as well as relationships changes that may not have been originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. This counselor consistently assesses your treatment for appropriate progress. If a situation fails to improve or if a situation deteriorates, this counselor will provide referral to another professional for consultation or treatment.

Moreover, those who are committed to the process *usually* get better. Most clients should attend counseling on a weekly or bi-monthly basis to address their (or their child's) therapeutic goals. Depending on your/your child's concerns, counseling can range from short-term (approximately 3-6 months) or long-term (6 months to a year or longer).

### FEES AND CANCELLATION POLICY

A counseling session is 45-50 minutes in length and requires a payment that adheres to your insurance policies and benefits. If you do not have insurance, a private payment fee can be arranged based on customary charges. Payment is due at the beginning of each session and cash, check, or credit cards are accepted. A $50.00 fee will apply for a returned check.______ patient's/parent/legal guardian initials.

It is very important that every effort be made to keep, and to be on time, for scheduled appointments. If you need to cancel an appointment, please notify the therapist as soon as possible. **A full session fee of 95.00 will apply when a patient does not show or does not cancel before twenty-four hours of their appointment time, unless due to unforeseeable events to be determined by the therapist. Clients who consistently reschedule and/or no-show more than three (3) times for their scheduled appointment times will be terminated and referred to another mental health professional.**

**MEDICAID:** Individuals with Medicaid must make every effort to insure that their Medicaid remains ACTIVE. Non-Active patients and/or failure to reactivate one's Medicaid will cause the patient to be placed on a temporary hold until the patient's Medicaid is reactivated. If the patient's well-being is at-risk for greater mental health concerns and the patient must be seen, the patient will be responsible for the following fee (per 45-50 minute session):__________. _______ patient's/parent or legal guardian initials

### LIMITS OF CONFIDENTIALITY:

Texas laws and HIPPA regulations on confidentiality protect the privacy of all communications between a patient and an LPC. In the greater majority of situations, LPCs will only release information about their treatment to others if clients sign a written authorization form that meets certain legal requirements imposed by HIPPA. However, there are times when the therapist may use or disclose PHI without your consent or authorization, which include the following circumstances:

- Child abuse and/or neglect
- Elderly and/or handicapped abuse
- To avert a serious threat to health or safety of oneself or an identifiable other
- Health oversight by the therapist
- Judicial and administrative proceedings, required by law
- Worker's compensation and employer (See the Notice of Privacy Procedures (NPP) for further information.)

There are other situations that do not require such written authorizations. In such cases, patients are generally notified that such contact has taken place. Examples of such interaction are listed below:

- Counselors may occasionally find it helpful to consult with other mental health and health professionals about the case. During such consultations, every effort is made avoid revealing the identity of clients. Other essionals are also legally bound to keep the information confidential.

**PATIENT'S RIGHTS**

HIPAA provides patients with several new and/or expanded rights with regard to their Clinical Record and the protection of PHI. Patient's rights are as follows:

- Request limitations on disclosures of the PHI
- Request alternative channels of communication
- Review health information records, including psychotherapy notes
- Ask for a copy of their records, along with this notice
- Request that their records be amended or corrected
- Ask for an accounting of disclosures of PHI
- Determine location(s) to which PHI are sent
- File a compliant with regard to privacy violations

THERAPIST RESPONSIBILITIES

- Counselors are required by law to maintain the privacy of PHI and to provide patients with a notice of their legal duties and privacy practices with regard to PHI.
- The counselor may reserve the right to change the privacy policies and practices described in this notice. Unless they notify clients of such changes, however, counselors are required to abide by the terms currently in effect.
- If counselors revise their polices and/or procedures, they must provide clients with a revised notice, by mail or by an alternative form of notification, as per client's written request.

**SERVICES TO CHILDREN**

If patients are under 18 years of age and not legally emancipated, they should be aware that the law allows parents to examine their child's treatment records, unless the counselor believes that such a review would be harmful to the patient and to his/her treatment. Before providing any information to parents or guardians, counselors discuss the need to do so with patients and, if possible under the circumstances, to respond to any objections raised by their patients.

I verify that I am the legal parent, legal guardian, managing conservator, or a person designated by the court to have the authority to consent to provide psychological services for the child/children listed below. I represent that I am authorized to grant this consent for professional services and request that therapeutic services be provided for my child/children.

____________________________ ____________________________

Child's Name Parent/ Legal Guardian Signature

**COMPLAINTS**

If you have questions about this agreement, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact me by phone or mail. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to: The Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183; Phone: (512) 834-6658. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. This counselor will not retaliate against you for exercising your right to file a complaint.

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**REQUEST FOR PROFESSIONAL SERVICES/CONSENT FOR TREATMENT**

I have read, understand, have been advised, and have received a copy of this entire document by Anne Manske, MA-MFT, LPC, concerning the contents of this document.

I have also read, understand, and received a copy (if requested) of the **Notice of Privacy Procedures** (NPP), which is in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I understand the information put forth in the NPP and give the Covered Entity (CE) the ability to use and disclose my Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations (TPO).

____________________________ ________________

Patient/Parent or Legal Guardian Signature Date

____________________________ ________________

Anne Manske, MA-MFT, LPC Date