CONTRACT FOR SERVICES &
INFORMED CONSENT FOR TREATMENT

Cathy L. McGinnis, LCSW-S, RPT-S
Psychotherapist/Registered Play Therapist
Phone: 817-226-1940/ 817-275-9788 Fax: 817-299-8622
2313 Roosevelt Dr. Suite D
Arlington, TX 76016

A. Patient Information: Please list names of both child patient(s) and parent(s).

Patient(s) Name(s): ____

Marital Status: M D S W Living together Same sex relationship
Address: ____
City, State, Zip ____
Telephone (Home) ____
(Work) ____
(Cell) ____

Current Medications: ____
____
____

Emergency Contact:

You are authorizing Cathy to contact this person in the event she feels there is an emergency or life-threatening situation where outside support is necessary.

Name: ____
Address: ____
City, State, Zip ____
Telephone (Home) ______________________ (Work) ________________________
(Cell) ________________________ (Other) __________________________

B. Patient Under Age 18:

Father's name: ____
Mother's name: ____
Does the child reside with father, mother, or both? _____________________________
If parents are divorced, which parent has managing conservatorship? ____________
If parents have joint managing conservatorship, please specify ______Yes ______ No
If parents are divorced, you **MUST** provide a copy of the divorce decree for the file.

C. Informed Consent for Treatment:

Cathy L. McGinnis is a Licensed Clinical Social Worker-Supervisor (LCSW-S). Cathy is also a Registered Play Therapist-Supervisor (RPT-S) through the Association for Play Therapy. Cathy offers individual, couple, family, group and play therapy for children as young as 3 years of age. Cathy will consider a child younger than 3 if the child is verbal.

I hereby give my informed consent for treatment by:

CATHY L McGINNIS, LCSW-S, RPT-S for

{Name of patient(s)} ____.

I further certify that I agree to and understand the following conditions of treatment:

1. Any perceived intent by the patient to harm him/herself or any other person will be reported by the therapist to the appropriate authorities.
2. Any sexual and/or inappropriate physical contact or physical abuse by the patient to a minor, elderly and/or disabled will be reported by the therapist to the appropriate authorities.
3. Absolutely no recording devices or cell phones are allowed in session. You may leave your cell phones with one of the office managers.

D. Payment Contract:

1. Payment is required before each session begins. We accept cash, check, Mastercard, Visa and Discover cards. There will be a $25.00 fee for all returned checks.
    - The fee is $140.00 per session for a 50 minute session (non-legal).
    - Group sessions are $60.00 for 1 hour and 30 minutes.
    - The fee is $165.00 per session for a 50 minute session for any court ordered cases, or pending court cases, possible court cases, or Mediated Settlement Agreements.

2. **Failure to cancel an appointment within 24 HOURS of the scheduled appointment will result in full charge for the appointment.**

3. The patient is responsible for filing his/her own insurance. We will provide you with a receipt for each session that will include your diagnosis code and any other information needed to file for insurance, after payment is received. It is your responsibility to submit this receipt to your insurance provider for reimbursement. Please insure that you indicate to your insurance provider that all payments go directly to you. If, by chance, the insurance reimbursement comes to this office, it will be sent directly back to the insurance provider.

4. If copies of client files are requested/ordered (i.e. by Attorneys or Judges) the fee will be $25.00 for the first 20 pages and $0.50 per page thereafter along with the actual cost of shipping (under the Texas Medical Practice Act by the Texas Medical Board). This also applies if this office has to make copies of Divorce Decrees, Associate Judges Reports, etc. NOTE: In order to request copies of records, please contact the office and ask for a Patient Record Request Form. This form MUST be filled out before records can be released.

5. Any written reports will be billed at the hourly rate of $140.00. (This fee is the same for court related cases and non-court related cases).

6. Should the therapist be SUBPOENAED to testify in court or to give a deposition in Tarrant County, the charge will be $247.50 per hour (time + ½) for a **minimum** of 4 hours **($990.00)**. **If the testimony/deposition exceeds the 4 hour minimum, there will be an additional charge of $247.50 per every additional hour.**

    Should the therapist be SUBPOENAED to testify in court or to give a deposition outside of Tarrant County, the charge will be $247.50 per hour (time + ½) for a **minimum** of 6 hours **($1,485.00)**. **If the testimony/deposition exceeds the 6 hour minimum, there will be an additional charge of $247.50 per every additional hour.**

    There is a 48 hour cancellation policy for court and depositions. Should the court hearing/deposition be scheduled for Monday, this office needs to be notified **NO LATER** than 12:00 Noon on Thursday. **Any cancellations that occur after 12:00 noon Thursday and/or 48 hours before the scheduled court hearing/deposition are NON-**

REFUNDABLE. We accept Mastercard, Visa, Discover, Cash, Money Order or Cashier's Check for payment. **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THIS SERVICE. All payments are due 48 hours prior to the scheduled court hearing/deposition and no later than 12:00 Noon on Thursdays if court hearing/deposition is scheduled for a Monday.** NOTE: Travel time is included and is figured from when Cathy leaves the office to go to court/deposition location and to leave court/deposition location and return to the office.

7. Due to the complexity of some cases, it is necessary to provide additional time other than the 50 minute therapeutic hour that has been scheduled for an office visit. This will include reading emails and phone conversations with the patient, family members, emergency phone calls after hours, phone calls during the day that must be returned during Cathy's lunch hour or at the end of her day, phone conferences with other professionals (i.e. attorneys, therapists, school counselors, psychiatrist, primary care physicians) and etc. The fee schedule is as follows and will be due at the time of your next scheduled office visit. If you do not have an office visit scheduled a bill will be mailed to you and is due upon receipt. (This fee is the same for court related cases and non-court related cases).

Up to 15 minutes	$ 35.00	31 – 45 minutes	$ 105.00
16 – 30 minutes	$ 70.00	45 – 60 minutes	$ 140.00

By signing this CONTRACT FOR SERVICES AND INFORMED CONSENT, I hereby agree with the terms and conditions as stated above.

____________________________ ________________________
Patient or Parent Signature Date Signed

____________________________ ________________________
Patient or Parent Signature Date Signed

____________________________ ________________________
Cathy L. McGinnis, LCSW-S, RPT-S Date Signed
Psychotherapist/Registered Play Therapist

Cathy L. McGinnis, LCSW & Associates
Standard Authorization Mental Health Treatment

I, ______________________________[Name of Patient(s)], whose Date of Birth is/are ____________________,

authorize ______________________________[Name of Therapist] and/or her office staff to disclose to and/or obtain from:

1. Hospitals, treatment facilities, physicians, psychiatrists, psychologists, psychotherapists, social workers, counselors, and/or other health care professionals.
2. Federal, state, county, and/or local government agencies.
3. Teachers, schools, teaching facilities, principals, educational administrators, and other education professionals.
4. Judges, attorneys, paralegals and/or their office staff.

the following information:

Description of Information to be Disclosed

(Patient should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment

______Nursing/Medical Information
_____ Educational Information
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
______Progress Notes
______Other_______________________
______Other_______________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to ___________________________________[Name of Therapist] at 2313 Roosevelt Dr. Suite D, Arlington, TX 76016. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

This authorization does not expire unless you have provided a written request to the office of Cathy L. McGinnis, LCSW & Associates to terminate the authorization, or if services have been terminated.

Conditions

I further understand that ______________________________[Name of Therapist] will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: My therapist and/or her office staff will be unable to speak with my attorney, doctor, psychiatrist, school counselor and/or any other entity that may need information about my care.

© Popovits & Robinson, P.C. 2013

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

A photostatic copy of this Standard Authorization Form shall be considered as valid as the original.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient refuses to sign authorization

© Popovits & Robinson, P.C. 2013

CATHY L. McGINNIS, LCSW & ASSOCIATES
Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, ______________________________ [Name of Patient], authorize Cathy L. McGinnis, LCSW & Associates to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Cathy L. McGinnis, LCSW & Associates. Such conversation shall be documented by Cathy L. McGinnis, LCSW & Associates.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Cathy L. McGinnis, LCSW & Associates

____ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

© Popovits & Robinson, P.C. 2013

Cathy L. McGinnis, LCSW-S, RPT-S

Psychotherapist/ Registered Play Therapist

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient(s):____
DOB(s): ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Cathy L. McGinnis, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the office of Cathy L. McGinnis, LCSW & Associates.

____ _______________
Signature of Patient, Parent, Guardian or Personal Representative* **Date**

____ _______________
Signature of Patient, Parent, Guardian or Personal Representative* **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient Refuses to Acknowledge Receipt**:

© Popovits & Robinson, P.C. 2003

CATHY L. McGINNIS, LCSW-S, RPT-S

PSYCHOTHERAPIST / REGISTERED PLAY THERAPIST

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

© Popovits & Robinson, P.C. 2013

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

© Popovits & Robinson, P.C. 2013

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 2313 Roosevelt Dr. Suite D, Arlington, TX 76016.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

© Popovits & Robinson, P.C. 2013

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 2313 Roosevelt Dr. Suite D, Arlington, TX or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2014.

© Popovits & Robinson, P.C. 2013