New Patients of **Dr. Jane Phillips and Amy Lane**,

Welcome to the office of Jane Phillips, PhD, LCSW-S and Amy Lane, LMSW. We look forward to working with you.

Please complete and sign all attached documents.

Sessions will last **45-50 minutes**. I ask that you be on time. I will do my best to do the same. Please understand there are times when I may run behind schedule due to crisis or emergency situations. In these cases, your session will still last the entire 45 minutes.

Because our office space is shared with other professionals, we ask that you speak softly in the waiting area and hallways and note that we are unable to accommodate unsupervised or very young children.

Payment at the time of service will be requested in cash, check or credit card. If you choose to use your out-of-network benefits, I will be happy to provide you with a receipt that will allow you to do this. If our sessions occur electronically, payment will be expected prior to the session.

NEW CLIENT INFORMATION

Last Name of Client:			First Name:	Middle Name:
Address:			Date of Birth:	
City:			State:	Zip:
SS#:			Referred By:	

Home Phone: ( )		OK to call and leave message? ▫ Yes ▫ No; Best time to reach
Cell Phone: ( )		OK to call and leave message? ▫ Yes ▫ No; Best time to reach
Work Phone: ( )		OK to call and leave message? ▫ Yes ▫ No; Best time to reach
Email Address (optional):		OK to leave confidential, detailed message? ▫ Yes ▫ No

Person to be contacted in case of emergency :	Name:
Relationship to you:	Contact Phone: ( )

CONSENT FOR TREATMENT

I authorize and request that ____________________________ (name of therapist) carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

Signed by client: ______________________________________ **Date:** ________________________________

CONFIDENTIALITY

All information between counselor and client is held in strict confidence by the counselor, with the following exceptions:

1. The client authorizes release of information, by signature, as specified on the Release of Information Form.
2. Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.
3. The client presents a physical danger to self or others.
4. An officer of a court of law legally requests information.
5. Child/elder abuse/neglect is suspected.

Please note that in the latter two cases, we are required, by law, to inform legal authorities so that protective measures can be taken.

I have read and understand the HIPAA policy statement provided to me by my counselor:

Signed by client: ______________________________________ **Date:** ________________________________

PRESENTING ISSUES

Please describe your reasons for seeking counseling at this time (please include the approximate dates that you noticed pertinent symptoms, any thoughts of hurting yourself or others and any current, major life stressors):

MEDICAL HISTORY

Please list any prescription medications you are currently taking (name, dosage, frequency):

Please list any over-the-counter medications you are currently taking (name, dosage, frequency):

Please list any past or present medical conditions for which you have been treated:

Please list all know n allergies:

MENTAL HEALTH HISTORY

Have you ever received psychiatric or psychological treatment of any kind before? ▫ Yes ▫ No

If so, please provide information on the level of care: ▫ In-patient ▫ Out-patient ▫ Both

Please indicate the reason for your previous treatment:

When and w here w ere you in treatment?

How long w ere you in treatment?

HABITS AND SUBSTANCE USE

	Current usage	Most ever used
Coffee (cups/day)		
Cigarettes (packs/day)		
Alcohol (please specify type)		
Drugs (please specify type)		

FAMILY HISTORY

Please describe any medical or mental health conditions of your spouse, parents, siblings and/or children:

Please indicate the lev el at which your issues are affecting your life in the following areas:

	No effect	Little effect	Some effect	Much effect	Significant effect	Comments
Marriage/relationship						
Family						
Job/school performance						
Friendships						
Financial situation						
Phy sical health						
Sleeping habits						
Eating habits						
Anx iety lev el						
Mood						
Suicidal or self-harming thoughts						
Ability to concentrate						
Ability to manage anger						
Spirituality						

Amy Lane, LMSW
4200 Hulen Street, Suite 676
Fort Worth, Texas 76109

Professional Disclosure Statement

Qualifications: I am a Licensed Master Social Worker (LMSW) and received my degree from the University of Texas at Arlington. As an LMSW practicing clinical social work, I receive supervision from Jane Phillips, Ph.D., LCSW-S, who is a board approved Supervisor. I am licensed by the Texas State Board of Social Work Examiners and am qualified to counsel all ages, including children, individuals, families, and groups. I have extensive experience serving clients with sexual abuse and domestic violence trauma. I have experience as a children's group home supervisor, hospital adult behavioral health unit therapist, child therapist and homeschool tutor. If you would like additional information about my credentials or have questions, please feel free to ask me. As an LMSW, I have received training in multiple therapeutic interventions, including Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). The interventions used will be determined by the patient's expressed needs.

Nature of Psychotherapy: For individuals with distress in life, difficulties in interpersonal relationships, and life transition problems, psychotherapy provides a safe environment to address one's values, distorted thoughts, background issues, and temperament which might contribute to one's current feelings and behaviors. By developing an understanding of these factors, it is possible to gain a sense of control and make purposeful choices about how to live, thereby attaining greater life satisfaction. The therapist and client, together, will set practical, realistic goals. Outside of therapy, the client has the opportunity to process and practice what has been talked about in therapy sessions. As a professional, the therapist will provide an environment for honest reflection and healing. The therapist and client will frequently evaluate progress, and adjust the course as needed.

Psychotherapy Relationship: Most individual sessions occur weekly and last 45 to 50 minutes, unless we are using EMDR. In this case, sessions may last 60-90 minutes. The nature of counseling often requires the client to share personal information that may be intimate psychologically. However, our relationship will remain professional on all levels. I ask that you abstain from inviting me to participate in personal outings, social media sites, gift giving, or writing references for you. If we meet in public, I will smile as I do with others in general but will not approach or engage you or your family in conversations to retain confidentiality.

Effects of Psychotherapy: Do be advised that, as part of the therapeutic process, some painful memories and/or feelings may arise during our sessions. The benefits, though, are learning new skills and methods of dealing with stressors, situations, and feelings, and working through your problems to find resolution. Counseling requires work on the part of the client; therefore, no guarantees are made that you will feel better or resolve your problems. However, I will use therapeutic interventions to help you make progress through your own personal insight and healing.

Patient Rights: The length of therapy varies depending on client goals, motivation, and need. Some clients can achieve therapy goals within a few sessions, while others may require several months or years of counseling. Reviewing progress toward goals will occur routinely. If there are techniques that you feel are not helpful or would like to suggest modifying, please let me know. As the client, you will be in control of participation and may decide to end therapy at any time. If you determine to end therapy before anticipated, I ask that you participate in a termination session to complete our time together and review progress and outcomes, as well as receive referrals if necessary.

My hope is that your endeavors during this season of therapy will constitute a positive experience of learning, growth, and healing.

Cancellations: I will do my best to respect your time and appreciate the same from you. Your appointment time belongs to only you. If you cannot make your appointment, please give me 24-hour notice so that I may fill that time slot with someone who may be waiting for services. In the absence of your notification, you will be billed **$85 for the missed session**. If you are absent for two or more consecutive sessions, I may ask to terminate the therapeutic relationship and provide you with referrals to other area services.

Referrals: I will continue to receive education and comply with social work licensing requirements for training, ethics, and professional growth. However, if you are in need of services that I and/or you believe to be above my educational level for appropriate treatment, I will refer you to another provider or agency that is better equipped to provide these services. The responsibility to investigate these resources will be yours unless a specific referral is required and requested. We would review these referrals together as needed.

Records and Confidentiality: All of our communication becomes part of the clinical record. Records are the property of Jane Phillips, Ph.D., LCSW-S, but you have a right to the information within your record. Most communications are confidential, but the following limitations and exceptions do exist: (a) you provide me with your consent to release information; (b) I have reasonable suspicion that you are a threat to yourself or someone else; (c) you disclose abuse or neglect of a child, elderly, or disabled person; (d) you disclose sexual contact with another mental health professional; (e) I am ordered by the court to disclose information; (f) you involve me in a lawsuit and I need to release specific information in order to receive compensation for services rendered; or (h) I am otherwise required by law to release information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

If your minor child is my patient, please allow your child confidentiality in counseling. Please do not ask your child what s/he discussed in counseling and please do not ask your child if s/he “had fun” in play-based therapy. Play-based therapy often requires emotional work for the child and could not be deemed fun. If there is a matter of urgent concern (e.g. suicidality, self-harm thoughts, thoughts of hurting others, dangerous behaviors), I will inform you and your co-parent. There will be no privileged communication between me and parents/guardians. In other words, if one parent communicates with me, I have the right to convey the content of the communication to the other parent/guardian, even if the parents are no longer married or are involved in a custody dispute, unless a court order specifically restricts this disclosure.

Few experiences in life can be as enriching as the journey of self-discovery and personal transformation. My goal is to help you along your own path of progress as you become the person you desire to be.

By your signature below, you are indicating that you have understood and agreed to this statement, and that any questions you had about this statement were answered to your satisfaction. By your signature, you verify accuracy of this statement and acknowledge your commitment to conform to its specifications.

_______________________________________ __________________

Client/Guardian Signature Date

_______________________________________ __________________

Counselor Name Date

Amy Lane, LMSW

(Supervised by Jane Phillips, PhD, LCSW-S)

Offices of Jane Phillips, Ph.D., LCSW-S

HIPAA Compliance Standards

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.

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.

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 682-225-6990.

- **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.
- **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 682-225-6990 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 2013.

I acknowledge receipt of this notice.

Client Name:____ Date: _________________

Signature: ____

____

Reason Given by Client for Refusing to Sign this Notice

Financial Policy

Effective April 1, 2020

I,____, have requested services from Jane Phillips, PhD, LCSW-S or LMSW under Dr. Phillips's supervision and I agree to pay for services at the following rates and to abide by the terms outlined in the contract and the attached new patient information. All checks are to be made out to Dr. Jane Phillips (not an LMSW):

	Dr. Phillips, LCSW-S	**LMSW**
Evaluative Interview	$190	$150
General Counseling (45-50 minutes)	$140 per session	$110 per session
Family or Couples' Therapy	$190 per session	$150 per session
Court Related counseling*	$225 per session	n/a
EMDR therapy	n/a	$130 per session
General Telephone communication	$190 per hour (pro-rated)	$150 per hour (pro-rated)
General Report Preparation	$190 per hour (pro-rated)	$150 per hour (pro-rated)
Court-related contacts**	$250 per hour (pro-rated)	n/a
Email Communication (except scheduling)	$45 per email	$45 per email

* Individual (adult or child), couple, or family counseling that is either ordered by a court, as a result of an agreed court order, mediated settlement agreement, or Rule 11 agreement, or is in regard to or related to a divorce, court case, or legal matter. Will also apply if referred by a Parenting Facilitator or Parenting Coordinator. (Ms. Lane does not accept court-related cases).

***This includes communication with attorneys, court caseworkers, judges, parenting facilitators/coordinators*

Even though I may subpoena Jane Phillips, PhD, LCSW-S to court, I understand that it does not mean that her testimony will be solely in my favor. She will testify to the facts of the case and her professional opinion. A deposit of $1500.00 is required prior to her attendance at court, should my attorney or I subpoena Dr. Phillips. Should my attorney or the Court cancel the request for her appearance, with less than 48 hours' notice, $750 of the deposit will be refunded. If the appearance is cancelled more than 48 hours in advance, the entire deposit (less any time already spent in preparation) will be refunded.

Client initials: ___________

If it is necessary to have a session longer than 45-50 minutes, the fee will be pro-rated for each additional 15 minutes. All fees are due upon receipt of services unless prior arrangements have been made. I understand that I may access my out-of-network benefits, if I have them, and my therapist will provide receipts with the necessary information for me to file for these.

Client initials: ___________

It is the nature of therapy to devote an entire 45-50 minutes for each appointment. This office has a full practice and there is often a waiting list for clients. Because of this, I acknowledge that it is very important to give **at least 24 hours' notice** in the event I need to cancel or re-schedule an appointment so another client can be scheduled at that time. In the event that I do not keep a scheduled appointment and fail to give 24 hours' notice, I will be required to **pay $85.00 f**or each appointment that is a late cancellation (less than 24 hours' notice) or "no-show." Insurance companies/Medicare will NOT pay for this.

Client initials: ___________

I acknowledge that if I am delinquent in the payment of my account, my therapist may not schedule further appointments until my account is paid in full. No reports will be generated; this includes EAP reports, court documents, letters of referral, etc. until the balance is paid in full. If my check is returned for insufficient funds, the amount of the check, plus any other outstanding checks, plus a $35.00 NSF fee will need to be paid immediately by cash or credit card. By signing below, I specifically authorize the card payment of any balances due according to this policy.

Client initials: ___________

If I choose to join group therapy, I will be responsible for payment for the group session regardless of my attendance. Group size is limited and my joining reserves a place for me. Therefore, payment must be made to keep the space.

Client initials: ___________

I understand and agree that Dr. Phillips's office accepts credit card payments, and I may wish to use a credit card to pay some or all of my fees with Dr. Phillips's office. I understand that a receipt may be sent by email to the address that I provide. I further understand that Dr. Phillips cannot assure the privacy of such emails, and I accept and agree that Dr. Phillips may send email receipts to the following email address or an email address I provide at the time my credit card is charged.

Email address: ____**Client initials:**________

I have read and understood the terms of this agreement and by my signature agree to all terms contained herein.

____ ____

Client Signature **Date** **Therapist signature** **Date**

For clients of Dr. Phillips and Ms. Lane, please note that the following email and technology policy has been implemented. Your signature below indicates your acceptance of these terms.

EMAIL AND TECHNOLOGY POLICY

It is our office's practice to use email only for communication of basic information. It is not used as a medium for therapy or as an alternative for phone calls or office visits. Please keep in mind that, although our office uses a secure provider for email services, because the Internet is complex, our office cannot be responsible for the confidentiality of the information that is shared via email. You are urged to use care with any information you provide through email to your therapist. There may also be times where your therapist receives, but does not respond to your email. Your therapist's lack of response does not indicate a lack of interest. She will respond if she believes it is appropriate and/or necessary. If she does respond to an email, a charge of $45 per email response (other than scheduling) will apply.

DO NOT USE EMAIL TO COMMUNICATE IN A CRISIS. If you are in crisis, call 911 or go to your nearest emergency room.

SOCIAL MEDIA

Your therapist does not engage in communication or relationships via social media with patients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter your therapist through social media or the internet, please feel free to discuss this with her in session. The therapy relationship is of a professional nature rather than social. Your therapist does not respond to messages or accept "friend" requests from current or former clients on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy.

Dr. Phillips or Ms. Lane would never post information about a client on a public website. We ask that you respect your therapist's privacy and refrain from posting any "reviews" or other information regarding her or her practice on any website such as HealthGrades, Angie's List, or other forum for posting public reviews of health care providers. By your signature below, you agree that you will not post any "review" or any other information on any website without Dr. Phillips's or Ms. Lane's prior written permission. If we believe that you have violated this agreement, we reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

INTERACTIONS OUTSIDE THE OFFICE

If you and Dr. Phillips or Ms. Lane happen to encounter each other outside of the professional setting, your therapist will not address you unless you speak to her first. This is also for the protection of your privacy from those persons who may be with you. Dr. Phillips and Ms. Lane happily return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

TEXT MESSAGING

This psychotherapy practice does **NOT** use text messaging as a form of communication. Please do not send text messages. If a text message is received, it will be deleted without being read.

AUDIO OR VISUAL RECORDING

Recording of sessions, by any means, is NOT permitted without the permission, in writing, of ALL parties. This includes telephone calls and electronic therapy sessions as well as face-to-face sessions.

By my signature below, I agree to abide by these policies.

____ ____________

Signature Date

____ ____________

Witness Date