Shayne Wade, MA, LMFT
18315 Bracken Dr. Ste 4, San Antonio, TX 78266
Office Phone: 210.646.4658
Email: shaynewade@shaynewade.com
Website: www.shaynewade.com

Counselor-Client Services Agreement

Welcome to my practice. This Agreement contains important information about my professional services and office policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provided new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or it you have not satisfied any financial obligations you have incurred.

The Process of Counseling: Counseling isn't necessarily a concrete procedure that follows a step-by-step assessment and process. The process and relationship is an ever growing procedure that can vary based on the personalities of the client and the counselor, the particular problems being addressed and the approaches used. The benefits of counseling may include and are not limited to providing insight, improving upon social interactions and interpersonal relationships, dealing with the natural stresses of life and resolving conflict and specific problems. Striving to achieve these benefits requires effort on the part of the client and the counselor both during and out of session. Counseling is a collaborative process that necessitates your active involvement, honesty, and openness in order to progress toward your goals. Given the work required for personal growth and change to occur, counseling can also involve risks. Since counseling often involves discussing difficult aspects of your life, you may experience uncomfortable feelings or strong reactions. Making changes in you life can sometimes be disruptive to you current relationships as well as challenge long held assumptions or behaviors. There can be no guarantees in counseling, due to the overall complexity of this process and the multiple variables brought into it by each individual client.
The duration of counseling differs for each individual. Factors such as goals, motivation, life circumstances, and duration/extent of the issues(s) determine whether treatment requires weeks, months, or years. We will periodically discuss your progress. You will be encouraged to express your thoughts and feelings regarding your counseling and our therapeutic relationship. It is important that any concerns either of us might have about the appropriateness or effectiveness of treatment be addressed. Counseling is a voluntary process and while you maintain the right to discontinue at any time, collaboratively exploring and discussing termination is an important part of the counseling process. It is important for you to initiate a discussion about termination if you are considering it.

Appointment Scheduling: I will generally schedule one 50-minute session per week; a regularly scheduled appointment will be worked out as one becomes available. Your collaboration regarding the punctuality of starting and ending sessions at the appointed times will be appreciated. Sessions may, by previous arrangement, vary in length or frequency. Adjunctive therapies, such as weekly group counseling, may be recommended and scheduled as appropriate.

Cancellations: A minimum of twenty-four (24) hours (i.e. one full business day) notice is required for cancellation of an appointment. For example, a 6:00pm Monday appointment would need to be cancelled by 6:00pm of the preceding Friday. The full fee will be charged for missed appointments without such notification. Exceptions will be discussed as appropriate. As spaces are reserved for members of counseling groups even in their absence, group members are responsible for full payment of missed sessions. Insurance companies typically do not reimburse for missed sessions.

Fees: My basic fee is $_____ per fifty (50) minute individual, couples or family counseling session. You will be informed in advance of any fee increases. You may anticipate periodic reviews (typically annually) of my fees. In addition to counseling appointments, I charge my basic fee (pro-rated) for other professional services (e.g. report writing, telephone conversations five minutes or longer, attendance at meetings you have authorized, preparation of and duplication of records or treatment summaries, and clinical review forms for insurance).

Payment for Service: You are expected to pay for services at the time they are provided. Payment may be made by check or cash. You are responsible for payment of all fees even if you plan to seek insurance reimbursement. Receipts for paid services will be provided upon request. You will be responsible for returned check fees charged by banks. Professional collection may be utilized if accounts become 90 days past due; such action would involve disclosure of your name, nature of service provided and amount due.

It is imperative that you determine the resources (insurance and/or out of pocket) available to you so that you can make a realistic assessment regarding your ability to pursue the recommended course of counseling. Should it be unrealistic for you to complete the recommended treatment, I will be happy to assist you in identifying other therapeutic options.

Insurance Reimbursement: You are responsible for full payment at the time of service. I do not contract for payment from insurance companies. Your health insurance policy may provide some coverage for mental health treatment that makes you eligible for reimbursement. Upon request you will be furnished with a receipt that you may submit to your insurance company if you choose to seek reimbursement. It is your responsibility to find out exactly what mental health services your insurance company covers. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before therapy is completed. You may need to explore your out-of-network service and reimbursement options, as I am not a participating provider in most plans. Some plans require pre-authorization, selection of a counselor from their provider panel, short-term treatment, or utilization of fixed fee schedules.

You should be aware that your contract with your health insurance requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes, I am required to provide additional clinical information such as treatment plans, periodic status reports, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement you agree that I can provide requested information to your carrier. Should you have concerns in this regard, it is important to remember that you have the right to pay for my services yourself.

Telephone and After-Hours Procedures: I am typically not immediately available by phone. My telephone is answered by voice mail. I make an effort to return your call on the same business day. Calls received after business hours, weekends, or holidays will be responded to upon my return to the office. Telephone calls typically are limited to scheduling arrangements. Telephone counseling sessions maybe considered and scheduled under certain circumstances. When I will be unavailable for an extended time (such as vacation) I will provide you with the name of a colleague to contact, if necessary, and/or leave

that information on my voice mail. If you need immediate emergency assistance, contact your family physician, the nearest emergency room or one of the services listed below:

24hr Crisis Help Line-	(210) 223-7233
Battered Women's & Children's Shelter Hotline-	(210) 733-8810
San Antonio State Hospital-	(210) 532-8811
Laurel Ridge Treatment Center-	(210) 491-9400
General Emergency Number-	911

Inclement Weather: In the event of inclement weather, please call my office telephone number to hear instructions. If area schools are closed and there is a travel advisory, my office will most likely be closed. If the situation is unclear, take care to insure your safety. Please call to advise regarding cancellation and to request for rescheduling of your missed appointment.

Ethical and Professional Standards: As a Counselor, I abide by the ethics and standards of my profession. I will be pleased to discuss any questions you may have regarding these guidelines; I will initiate such discussions as needed. My policy regarding issues such as requests for bartering or receiving a gift is to make that decision in collaboration with the client. The firm underlying principle in decision making is focus on what is in the best interest of the client and his or her therapeutic progress. Any questions regarding these complex issues should be initiated prior to any decision.

Records: You should be aware that, pursuant to HIPAA, I keep protected health information about you. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because there are professional records, they can be misinterpreted and /or upsetting to untrained readers. If you choose to review your records, therefore, I recommend that you review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. I am allowed to charge a copying fee (and for certain other expenses). The exceptions to this policy are contained in the attached Notice.

In addition, I might keep a set of Counseling Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Counseling Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They may also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Counseling Notes are kept separate from you Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Counseling Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your counseling Notes unless it is determined that release would be harmful to your physical, mental or emotional heath.

Client Rights: HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, demining the location to which protected information disclosures are sent, having any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy of this Agreement and the Notice.

Confidentiality: The law protects the privacy of communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation or supervision, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will use my discretion to determine whether it would be beneficial to discuss these consultations with you.
- Disclosures required by heath insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- I may have a professional will which includes a list of my clients which can be accessed by a pre-determined responsible counselor in the case of my death or serious disability so that your needs at that time could be addressed.
- If a client seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the client to himself/herself or others, or there is a probability of immediate mental or emotional injury to the client.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization (Regarding minors, it is my policy that parents respect the privacy of your counseling. The law may provide your parents or legal guardians the right to review your treatment records if you are under eighteen years of age. I will ask your permission to discuss your counseling with them in response to their questions and/or as you or I feel would be helpful. When doing so, I will endeavor to offer only general information about your counseling, unless we have agreed otherwise. Exceptions to this include imminent threat of harm to oneself or to others, and child abuse or neglect; these situations are discussed in the Notice):

- If you are involved in a court proceeding and request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in, or contemplation, litigation, you should consult with you attorney to determine whether a court would be likely to order me to disclose information.
- If you tell me of a sexual involvement with a mental health professional who was involved with your care, I am required to report this to the appropriate State Board. If a government agency is requesting the information for heath oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such a report is filed, I may be required to provide additional information.
- If I determine that there is a probability that the client will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Issues related to the complexity of confidentiality and management of neutrality in couples and family counseling will be discussed as needed. When a couple or a family is the client rather than an individual, it will be necessary to establish clarity about sharing information. If a change of format involving who is the client becomes necessary or useful, there will be discussion and disclosure of issues related to such a change.

Members of counseling groups are required to maintain confidentiality regarding the identity of group members and personal information disclosed during group session.

While this written summary of confidentiality and exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex; in situations where specific advice is needed, formal legal advice may be required.

Client Signature: _____ Date: _____

Parent/Guardian Signature(s): _____ Date: _____

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INFORMED CONSENT

Insurance: I do not accept assignment of benefits, nor do I participate in managed care insurance plans. If you have insurance which will provide coverage for treatment by me as the provider, I will provide you with a statement which you can submit for reimbursement. If it is necessary for you to submit a claim form, I will assist you with completion if you provide the appropriate claim form. You are responsible for mailing your claim to the insurance company and tracking your reimbursement. You are responsible for the full fee regardless of your insurance company's reimbursement policies. Your regular fee will be charge for any additional professional services rendered for your provider at your request, such as phone contracts over five minutes and preparation of special forms.

Therapeutic Goals: Setting goals is an important part of psychotherapy. Please list your goals below, they may evolve throughout the therapeutic process but this gives us a good point from which to start:

_____
_____
_____
_____

Client: The therapeutic relationship provides a safe place where in the client can share information and explorer feelings with specific client-counselor privledges. Please identify in the space provided who is the client in this therapeutic relationship (There may be more than one person).

_____ _____
_____ _____

Fee: Your payment is to be paid in full at the time of each session. Any exception to this policy will be determined on a case-to-case basis and should be made in advance. Your fee per 50 minute visit is $_____. Modifications in session time will be prorated based on that fee. Phone sessions over five minutes will be charged at that established fee. I accept cash or check. In the unlikely event that check funds are insufficient, I will collect the returned check fee charged by my bank. Fees are subject to change annually and you will be notified in advance of any change in fee.

No-Show and Cancellation Policy: When you schedule an appointment with me, that time is reserved for you. **It is required to that you give 24 hour (one business day) notice for cancellation** or you will be charged for the time at the established fee.

Release of Information: All information shared in this treatment is confidential except in circumstances governed by law and under supervision. If you would like for me to confer with someone, such as an insurance provider or other health care professional, you will need to sign a Release of Information form. This permission can be revoked by you at any time. There is no way to ensure confidentiality once information is released to an insurance company.

Emergencies: I am often not immediately available by phone. Should I not be available, call one of the emergency numbers given to you at your initial visit, 911, your physician, or go to the Emergency Room of the nearest hospital.

Statement of Understanding:

I agree that, in signing this Informed Consent form, I have read and fully understand the information contained herein

Client Signature: _____ Date: _____

Parent/Guardian Signature(s): _____ Date: _____

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
I am required by law to maintain the privacy of your health information and provide you with a description of my privacy practices. This notice will also describe your rights and certain obligations I have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY
Your health information is personal. I am committed to protecting your health information. I create a record of the care and services you receive at this office. I need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations Requiring Your Advance Consent.

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. To help clarify these terms, here are some definitions:
-"PHI" refers to information in your health record that could identify you.
- For Treatment. "*Treatment*" is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist, counselor or social worker.
- For Payment. "*Payment*" is when we obtain reimbursement for your healthcare. An example of payment is when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. I may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
· For Healthcare Operations. "*Healthcare Operations*" are activities that related to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, post cards, and other mailings.
· Use. "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
· Disclosure. "*Disclosure*" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse. If I have reasonable cause to suspect that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 yours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- Adult and Domestic Abuse. If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- Abuse by a Therapist. If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment, I will report this to the appropriate State Examining Board.
- Health Oversight: If a complaint is filed against a therapist with the appropriate overseeing State Board (The Texas State Board of Examiners of Psychologists, The Texas Board of Medical Examiners, the Texas State Board of Social Work Examiners, or the Texas State Board of Licensed Professional Counselors); they have the authority to subpoena confidential mental health information from the therapist relevant to that complaint.
and marriage and family therapists we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety. If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- Worker's Compensation. If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor/Social Worker/Marriage and Family Therapist's Duties
You have the following rights regarding the PHI that this office maintains about you.
- Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your information to another address.) To request confidential communications, you must complete my request form in writing and submit it to me. I will accommodate all reasonable requests.
- Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. It may take several days to arrange for the inspection of your records and/or to copy your records. A fee may be associated with the copying of your records.
- Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must complete my request form and submit it in writing to me. In addition, you must provide a reason that supports your request. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On

your request, I will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to me.
- Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from me upon request.

Counselor Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

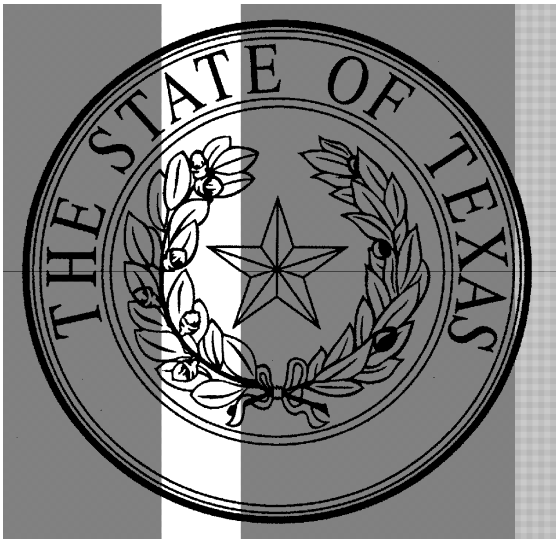
V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy, please talk to me about your concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 30th, 2013. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will post a copy of any revised Notice in this office. Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide me such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that I am unable to take back any disclosures I have already made with your permission, and I am required to retain my records of care that I provide to you.



FILE A COMPLAINT:

Texas Administrative Code
Examining Boards
Texas State Board of Examiners of Marriage and Family Therapists
Licensure and Regulation of Marriage and Family Therapists

To file a complaint you may contact the Texas State Board of Examiners of Marriage and Family Therapist via phone, electronic communication or mail by using the below information;

Texas State Board of Examiners of Marriage and Family Therapists
Professional Licensing and Certification Unit
Texas Department of State Health Services MC-1982
P.O. Box 149347
Austin, Texas 78714-9347
Phone: (512) 834-6657
E-mail: mft@dshs.state.tx.us
Website: http://www.dshs.state.tx.us/mft/default.shtm

Payment Contract for Services

Name(s): _____

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

Bill to: Person responsible for payment of account: _____

_____

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

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay Shayne Wade, hereafter referred to as the clinic, a rate of $ _____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).
A fee of $ _____ is charged for group counseling. The fee for testing includes scoring and report-writing time.
A full fee is charged for missed appointments or cancellations with less that 24 hours' notice.
A fee of $ _____ per hour is charged for additional services, such as court appearances, extra report writing time, and any other services apart from the counseling session.

PART TWO ALL CLIENTS

Payments are due at the time of service. There is a 5% per month interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____

Date: _____/_____/_____

Financial Policy

Here at my practice (hereafter referred to as the clinic) I am committed to providing caring and professional mental health care to all of my clients. As part of the delivery of mental health services, I have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; I am not part of the contract with you and your insurance company. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds. Payments not received after 120 days are subject to collections. A 5% per month interest rate is charged for accounts over 60 days.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check or cash. _____

Questions regarding the financial policies can be answered by the clinic.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account; _____
Date:_____/_____/_____

Co-responsible party: _____
Date:_____/_____/_____

Signature Page for Receipt of HIPAA and Services Agreement Documents

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Email: shaynewade@shaynewade.com
Website: www.shaynewade.com

My signature below acknowledges that I have read, understand and received a copy of:

- Counselor-Client Services Agreement
- Informed Consent
- Notice of Policies and Practices to Protect the Privacy of Your Health Information
- Complaints
- Financial Policy
- Payment Contract For Services

I understand that I can discuss these documents and any issues related to them with my therapist at any time.

Signature of Client Date

Printed Name of Client

Signature of Client's Representative Date

Name and Relationship of Client's Representative (guardian, authorized representative, or parent)