TEXAS PSYCHOLOGY SERVICES

1110 Nasa Parkway Suite 307
Houston, TX 77058
281-956-1032

PATIENT INFORMATION

NAME:_____

EMAIL ADDRESS **(FOR USEFUL, INFORMATIVE UPDATES/RESOURCES):**

_____

PHONE: _____(H)_____(W)

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____MARITAL STATUS_____

D.O.B.:_____AGE:_____SEX:_____SOCIAL SEC. #_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

FAMILY INFORMATION

NAME OF SPOUSE OR PARENT:_____RELATIONSHIP:_____

PHONE: _____(H)_____(W)

ADDRESS:_____

CITY: _____ STATE _____ ZIP _____

D.O.B.:_____SS#_____ MARITAL STATUS _____

EMPLOYER:_____

INSURED INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT:_____

PHONE: _____ (H) _____ (W)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SEX: _____ SOCIAL SECURITY: _____

EMPLOYER: _____

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PLEASE LIST CURRENT MEDICATIONS FOR MEDICAL AND PSYCHIATRIC CONDITIONS:

NAME OF MEDICATION	DOSAGE / FREQUENCY	START DATE	SIDE EFFECTS
_____	_____	_____	___Y ___N
_____	_____	_____	___Y ___N
_____	_____	_____	___Y ___N
_____	_____	_____	___Y ___N

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY: CASH_____CHECK____CREDIT CARD_____

TEXAS DRIVERS LISCENSE#_____

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. **IF FOR ANY REASON, A SCHEDULED APPOINTMENT CANNOT BE KEPT, CANCEL 24 BUSINESS HOURS BEFORE THE APPOINTMENT, OR STANDARD OFFICE CHARGES OF $190 ITINAL, $175 FOLLOW-UP AND $225.00 FORENSIC WILL BE MADE**. THE CREDIT CARD NUMBER YOU GAVE US WHEN YOU SCHEDULED YOUR INITIAL APPOINTMENT WILL GUARANTEE THIS APPOINTMENT AND ALL FUTURE APPOINTMENTS.

Dr. Sheri Schneidman Corning is a Clinical Psychologist licensed in the State of Texas since 1985. Dr. Bryan J. Sweeney is a psychologist licensed in the state of Texas since 2006.
Dr. Chrystina Bacek Kachantones is a psychologist licensed in the state of Texas since 2008.
Dr. Sneha Desai is a psychologist licensed in the state of Texas since 2011
Dr. Ruchi Kukreja is a provisionally licensed psychologist in the state of Texas since 2013

I HAVE READ ALL INFORMATION ON THE FOLLOWING PAGE, REGARDING FINANCIAL ARRANGEMENTS & INSURANCE BENEFITS AND HAVE COMPLETED THE ABOVE INFORMATION.
I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

_____ _____
SIGNATURE DATE

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ADDENDUM TO CONSENT FORM

In order to fully inform our patients and to be in compliance with all HIPPA requirements, the following statements should be explained and understood:

- Texas Psychology Services is owned and operated by Sheri Corning, PhD, Bryan J. Sweeney, PhD and Chrystina Bacek Kachantones, PhD.

- Any mental health professional other than Drs. Corning, Sweeney and Bacek have no ownership in Texas Psychology Services, all associates work solely as independent contractors for Texas Psychology Services/Sheri Corning, Ph.D, Bryan J. Sweeney, Ph.D and Chrystina Bacek Kachantones, Ph.D.

If you have any questions or concerns ask to speak with Angela Bella, our Office Manager.

Patient's Signature: _____

Witness Signature: _____

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I have provided Texas Psychology Services with my credit card number and authorize them to keep my signature on file, and to charge my credit card account for all insurance payments paid directly to me that were due to this office; for all missed appointments and for all balances.

If for any reason a scheduled appointment cannot be kept, you must cancel 24 business hours by phone (not email) before the appointment, or a standard office charge of $190 initial session, $175.00 regular sessions and $225.00 for Forensic session a charge will be made.

I understand that this form is valid while I am a patient unless I cancel the authorization through written notice to this clinic.

Patient's Name: _____

Charge Card Number: _____

Expiration Date: _____ V Code: _____

Cardholders Signature: X_____

Date: _____

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ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE BENEFITS

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

- Payment for services is due and payable at the time services are rendered. We accept cash, checks, Mastercard, Visa and American Express. Returned checks are subject to a $25 returned check fee. Any balance older than 30 days will be subject to additional collection fees and interest charges of 18% monthly on the unpaid balance.
- If for any reason your appointment cannot be kept, please call our office 24 business hours in advance or usual appointment charges ($190 New Patient, $175 Follow up, $225 Forensic) will be billed to the credit card you have on file with the office. The card you provided us when you scheduled your appointment will be used to guarantee this appointment and all future appointments.
- Authorization of insurance benefits is not a guarantee of payment for services rendered. You are ultimately responsible for any unpaid balance.
- It is your responsibility to notify our office immediately of any changes to your insurance.

_____ _____

Signature Date

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I give my permission for this office to leave detailed information at the following numbers:

_____HOME

_____WORK

_____CELL

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

LIMITS OF CONFIDENTIALITY

The contents of a counseling intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses information or a plan to harm another person, the health care profession is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client starts or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or that a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the personal representative of the deceased client has a right to access his/her records.

Professional Misconduct

Other health care professionals must report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professional are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of no emancipated minor clients have the right to access the client's records.

Patient Rights

You have the right to look or get copies of your patient records, with limited exceptions. You must make a request in writing to obtain these records. We will charge you a reasonable cost-base fee for expenses such as copying and staff time. You have the right to request that we amend our patient information. Your request must be made in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Other Provisions

When fee for services are not paid in a timely manner, collection agencies may be utilized n collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, case notes, testing, etc.) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and client's credit report may state the amount owed, time frame, and name of this clinic.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services (c) information received from other sources about the client (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, in kept in each file in the form of case notes.

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws to work under. In the event that this clinic or mental health professional must telephone the client for purposes such as appointment cancellations, or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

If you believe that your privacy rights have been violated, you may complain to this office, to the Secretary of Health and Human Services, or to Texas State Board of Examiners of Psychologists. Under no circumstances, will there be any retribution against any client for filing a complaint.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Privacy Practices. I agree to the above limits of confidentiality and understand their meanings and ramifications.

Patient's (or Guardian's) Signature_____ Date_____

Patient's Name (please print)_____

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I _____will not be using insurance and I am fully responsible for all payments. This agreement is between myself and Texas Psychology Services and does not involve insurance.

Texas Psychology Services understands that many individuals elect not to use their mental health coverage, because it may require our office to reveal your personal information or various other reasons. Hence, if you elect not to use your coverage you will be charged the rate of $190.00 for the initial visit and $175.00 for each additional visit.

If at anytime your status changes from self-pay to insurance, our office will begin filing your insurance claims from that date forward. In this case, we will only file future appointments and not any previous sessions. If your insurance provides our office with misinformation regarding your coverage (i.e., they tell us you have no coverage) we will not be responsible for their error.

_____ _____

Signature Date

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Office Policies Re: Records for Request

Any request to view or obtain a copy of a client's mental health records must be made in writing and sided and dated by the client or client's legal guardian. Records will be made available during regular business hours. Our office charges a fee of $25 for copying a client's records. Should the records request include a request that the records be shipped, the actual cost of shipping the records will be added to the $25 coping fee. Payment must be made by cash or credit card. Personal checks will not be accepted for payment. Once payment is received, the requested records will be mail by certified mail, return receipt requested. If a Business Records Affidavit is requested, a fee of $15 will be charged, and the Affidavit will not be signed until the fee is paid. The client or client's legal guardian will be responsible for the cost of the mobile notary. Within 30 days of receipt of the written records request and payment of all applicable fees, records will be provided. If it is determined that having access to the mental health records would be harmful to the client's physical, mental, or emotional health, a written statement attesting to this will be provided.

I have read and agree to the policies and terms outlined above

_____
Clients Name (please print)

_____
Name of Client's legal guardian if client is a minor (please print)

_____
Signature