PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides 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 this 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 if you have not satisfied any financial obligations you have incurred.

Psychological Services
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings
I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we**

both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for canceled sessions.

Professional Fees
My hourly fee is $200.00 In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

Contacting Me
Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail, which I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Limits On Confidentiality
The law protects the privacy of all communications between a client and a psychologist. 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, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

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 the client 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:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

If a client 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 client 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.

While this written summary of 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, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or 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 client's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another

mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request.

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; determining 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, the attached Notice form, and my privacy policies and procedures.

Billing And Payments
You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature of Client (or person acting for client):

Date:

Printed Name:

PSYCHOTHERAPY TELETHERAPY SERVICES AGREEMENT AND INFORMED CONSENT

1. Teletherapy, by definition, is the delivery of therapeutic services by which the therapist and client are not within the same physical location. This includes, but is not limited to, Webcam sessions, Telephone conversations, E-Mails, Text Messages, or any communication involving the Internet as a medium.
2. Unless I, the therapist, and you, the client, explicitly agree, our teletherapy exchange is confidential. Any information you disclose to me is held in the strictest confidence. However, if based on the information you disclose, I suspect abuse of children, the elderly, or people with disabilities, it is my duty to report this to the authorities, including Police, CPS, and APS.
3. I am legally and ethically able to provide teletherapy within the state of Texas when I deem it clinically appropriate and when you agree to it as an option. This teletherapy is governed by Texas laws and the regulations of my licensing board. It is the responsibility of you, the client, to inform me in advance if you will not be in Texas for your session. When you are physically in another state or country, I am required to also comply with the laws and professional licensure requirements of that state or country, which means, I cannot guarantee you teletherapy when you are out of Texas. To avoid a late-cancellation or a no-show fee, please let me know at least 48 hours in advance if you will be out of Texas for your session. To try to arrange teletherapy for future sessions when you will be out of Texas, please talk to me at least two weeks in advance during one of our sessions, and we can, on a case-by-case basis, see if teletherapy will be possible in your location. Ultimately, I will defer to the laws and regulations of my professional board in both Texas and your travel location as well as my clinical judgment to determine if teletherapy is viable, ethical, and appropriate.
4. It is your right to discontinue therapy services and/or teletherapy services at any time. It is also within the rights of the therapist to discontinue therapy or teletherapy if the therapist feels it is in your best interests.
5. Teletherapy should not be confused with face-to-face therapy, as it has the following restrictions: it is possible for a 3rd party within your environment, or the therapist's environment, to overhear the conversations being conducted. In addition, a 3rd party could hack ("man in the middle attack") and overhear or see the session as it is being conducted. Any documents or text messages could be obtained by a 3rd party. Viruses, Trojans, Worms, and other programs could reside on clients of therapist's computers which could send private information to a 3rd party. Due to these risks, it is important to maintain appropriate security measures. Firewalls, up-to-date virus scanners, and patched computer systems will help reduce the likelihood of a data breach; however, no method is 100% secure. By signing this form, you, the client, acknowledge these risks.
6. It is your responsibility to provide your own equipment in order to conduct the teletherapy session. This includes a computer, tablet, or smartphone, a webcam or camera built into their device, and Internet access to conduct the session. It is my responsibility to provide similar equipment in my environment.
7. It is your responsibility to make sure the environment chosen to conduct the teletherapy session is as private as possible. In this environment, it is your responsibility to keep distractions to a minimum. In addition, it is your responsibility to protect confidential information within their own environment (prevent anyone from listening in to the session from someone else in the home). It is my responsibility to do the same in my environment.

8. Video-Teletherapy sessions are typically conducted via Google Hangouts, a HIPAA-Compliant Video Conferencing software. Google Hangouts provides encryption and protects patient data via HIPAA, which is why it is chosen over Skype or other alternatives. If needed, I will provide instructions on how to use this technology. Teletherapy does not provide emergency services. If you are experiencing an emergency situation, call 911 or proceed to the nearest hospital emergency room for help, or contact your psychiatrist. If you are having suicidal thoughts, contact the National Suicide Prevention Lifeline at: 1-800-273-8255.
9. You have the right to request face to face counseling instead of teletherapy, as long as you can physically travel to the therapist's office and agree to meet the schedule of the therapist and as long as meeting face to face is safe for both client and therapist (e.g. it might not be safe during the Covid 19/global pandemic). Client can discontinue teletherapy services at any time.
10. Clients have a right to access their medical information and copies of medical records in accordance with HIPAA privacy rules, and the rules of the therapist's licensing board.
11. By signing this form, I am agreeing to pay Fabianna L Laby, PsyD the full cost of my session.
12. You, as the client, have a right to file a board complaint. You also have a right to verify my license online. I am licensed as a psychologist in the state of Texas and my license number is 31242.

For Psychologists:
To Make a Board Complaint: Call 1-800-821-3205 or visit
https://www.tsbep.texas.gov/how-to-file-a-complaint-enforcement

To Verify a License: Call 512-305-7700 or visit
https://vo.licensing.hpc.texas.gov/datamart/selSearchType.do

By signing this form, you agree to have read, understand, and agree to the information presented above:

Signature of Client (or person acting for client):

_____

Date:

_____

Printed Name:

_____

CLIENT INTAKE FORM

Note: If you have been a patient here before, please fill in only the information that has changed.

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____

Home Street Address: _____ Apt.: _____

City: _____ State: _____Zipcode: _____

Home/evening phone: _____

Calls will be discreet, but please indicate any restrictions: _____

Cell Phone: _____

E-Mail: _____

B. Referral

Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you?

C. Chief Concern

Please describe the main difficulty that has brought you to see me:

D. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?

Yes No

If yes, please indicate:
When? _____
From whom? _____
For what? _____
With what results? _____

2. Have you ever taken medications for psychiatric or emotional problems? Yes No
If yes, please indicate:
When? _____
From whom? _____
What medications? _____
For what? _____
With what results? _____

E. Your Medical Care
From whom or where do you get your medical care?
Clinic/doctor's name: _____
Phone: _____
Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

F. Your current employer
Employer: _____
Address: _____
Work phone: _____
Calls will be discreet, but please indicate any restrictions: _____

G. Marital/relationship history

Spouse's Name	Your age at marriage	Spouse's age at marriage	Divorced/widowed?

H. Children

Note: Indicate which are from a previous marriage or relationship with the letter P in the last column

Name	Current Age	Sex	School	Grade	Adjustment Problems	P

I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the client (or person acting for the client), request that the therapist named below provide professional services to me and I agree to pay this therapist's fee of $200.00 per session at the time of service.

To avoid payment for a missed session, I agree to cancel appointments 24 hours in advance.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that confidentiality to the patient is assured within the constraints of the law, but dates and fees for services provided may be released to a collection agency to assist in the collection of a delinquent balance.

Signature of Client (or person acting for client):

_____

Date:

_____

Printed Name:

_____

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