CLIENT INFORMATION

Client Legal Name:_____ DOB: ____/____/_____ Age: _____
Client Preferred Name:_____ Gender: _____
Address:_____

Parent/Guardian Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: ☐S ☐M ☐D ☐Other_____

Parent/Guardian Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: ☐S ☐M ☐D ☐Other_____

I agree to be contacted in the following manner (check all that apply):

☐ Cell phone: (_____) _____
- ☐ Detailed message ok
- ☐ Text message ok
- ☐ Name and call back number only

☐ Work phone: (_____) _____
- ☐ Detailed message ok
- ☐ Name and call back number only

☐ Home phone: (_____) _____
- ☐ Detailed message ok
- ☐ Name and call back number only

☐ Email:_____

☐ Other:_____

☐ Mail to home

☐ I wish to receive appointment reminders by ___ email and/or ___ text message. (check one or both)
☐ I do not wish to receive appointment reminders.

How were you referred to me?_____

Insurance (please complete insurance form for both in-network and out-of-network)
☐ Private pay, no insurance use
☐ In-Network insurance (please verify coverage with your plan)
☐ Out-of-Network insurance

Acknowledgement of HIPAA/Privacy Policy:
I have received a copy of this office's Notice of Privacy Practices. (see attached in this packet)

_____
Client/Guardian Signature Date

It is the responsibility of the client (or guardian) to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible.

Carolyn Mehlomakulu, LMFT-S, ATR-BC
13706 Research Blvd, Ste 114, Austin, TX 78750
Phone: (512) 660-7279 Fax: (888) 972-5053
carolyn@therapywithcarolyn.com

CONSENT FOR SERVICES: CANS ASSESSMENT

Client Name:_____ **Date:**_____

Parents/Guardians (for minor client):_____

Assessment Services: Client has been referred for a Child Adolescent Strengths and Needs Assessment (CANS) by DFPS. It is currently a requirement that all children in DFPS care receive this assessment upon entry to care and then yearly when they remain in care. Unless otherwise discussed, the agreed upon service is for assessment only and no ongoing psychotherapy relationship is established.

Psychotherapy Services: As part of the CANS assessment, I will provide recommendations that may include psychotherapy. Client may have the option to continue treatment with this therapist, but is free to seek another provider instead. I am happy to provide referrals to other therapists if you would like or if I am unavailable for ongoing treatment.

Fees: The CANS assessment is covered by the child's STAR Health Medicaid. Coverage of any additional services is dependent on medical necessity.

Guardian Involvement for Minor Clients: Participation of a current caregiver is necessary for the CANS assessment. I will also meet individually with the child for part of the assessment time. **A parent/guardian is required to remain on-site at all times.**

Cancellation Notice: All cancellations of appointments should be made at least 24 hours in advance. If appointments are cancelled in advance there is no fee for the cancelled session. Cancellations may be left on my voicemail at (512) 660-7279. **An administrative fee of $25.00 will be charged if you give less than 24-hour notice or no-show for a scheduled appointment. This fee is not covered by any insurance companies.**

Court: I do not testify in court as a witness and do not provide court testimony for marital or custody disputes. If I am required to testify in civil court, due to court order or subpoena, I will require payment in advance of my standard fee of $150.00 per hour during the entire time at the court or at the depositions, including travel time.

Confidentiality: Information that you discuss with a therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations (see Notice of Privacy Policy). However, you should be aware that the CANS assessment is intended to provide information to all parties involved in the care of the child. People with access to the CANS may include foster parents, DFPS/CPS caseworkers, CASA, future therapists providing treatment, and biological family of origin.

There are additional limits to confidentiality under any of the following circumstances:

1. If client is a serious danger to themselves
2. If you threaten serious harm to others
3. If I have reasonable suspicion or am told of abuse or neglect of a child, elder, or dependent adult
4. If I am ordered by a court to release records or as otherwise required by law
5. If you are using a mental health insurance policy to pay for your visits, I may be required to provide certain diagnostic and treatment information in order to obtain payment for services
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations

Access to Records: The CANS assessment is entered online into the secure eCans portal where information will be

stored. A copy of the assessment will also be available in the child's Health Passport, where foster parents and other involved parties can access a copy. I am unable to provide any other paper or electronic copy of the CANS assessment. All other treatment records are the property of this therapist and will be stored in a secure electronic health record. You may submit a written request for records, and I will determine whether it is appropriate to release these records.

Additional Contact with Therapist: You may call or email me for brief follow-up questions, to obtain referrals for ongoing therapy, or to schedule additional services. I am not always able to answer the phone, so please leave a voicemail and I will make an effort to return your call within 48 hours. In the case of a psychiatric emergency or crisis, for Travis County residents, please call Psychiatric Emergency Services: (512) 472-4357. For Williamson County residents, please call the Crisis Intervention Team at (800) 841-1255. In case of immediate emergency, please call 911.

Email: Email should not be used for a crisis or emergency situation as you may not receive an immediate response. Security of email cannot be guaranteed, and you may wish to avoid the transmission of confidential information in email. If you choose to email me, you are accepting this risk.

Text Messages: Text messaging should be used for scheduling issues only. If you need to discuss anything else between sessions, please call and leave me a voicemail.

Questions and Other Rights: If you have any questions about the above information or other questions related to your treatment, please feel free to discuss this with me. If you are unhappy with your treatment at any time, I hope that you will talk with me so that I can address your concerns. You have the right to considerate, safe, and respectful therapy, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian/Conservator Signature (if applicable) Date

_____ _____

Parent/Guardian/Conservator Signature (if applicable) Date

_____ _____

Therapist/Witness Signature Date

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HIPAA--Notice of Privacy Policy:

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 3, 2013, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that we maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practices, I will change this Notice and make a new Notice available upon request.

You may request a copy of our notice at any time. For more information about my practices or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment, Payment, and Healthcare Operations: I may use or disclose your health information to a physician or other healthcare provider providing treatment for you. I may use or disclose your health information for healthcare operations, such as quality assessment and improvement activities, to review the competence or qualifications of healthcare professionals, for evaluation of practitioner and provider performance, for conducting training programs, accreditation, certification, licensing, or credentialing activities. I may use and disclose your health information to obtain payment for services I provide to you.

Your Authorization: You may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Without written authorization, I will not disclose health information unless otherwise described in this notice.

Persons Involved in Care: I may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up health information.

Marketing Health Related Services: I will not use your health information for marketing communication.

Required by Law: I may use or disclose your health information when I am required by law to do so, or if a court of law orders your records.

Abuse, Neglect, or Threats of Harm: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. I may

disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: I may disclose military authorities the health information of Armed Forces under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients certain circumstances.

Appointment Reminders: I may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) as requested.

Patient Rights

Access: In most cases, you have the right to inspect and copy your medical and billing records. You must submit your request in writing. You have the right to request your records in electronic form. If you request a copy of information, I may charge a fee for the costs and time of copying. I may deny your request to inspect and copy information in some circumstances.

Disclosure Accounting: You have the right to receive an accounting of disclosures of your health information and may submit a written request for this account.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency). If paying out of pocket for services, you may restrict the release of information to your insurance provider.

Alternative Communication: You have the right to request in writing that I communicate with you about your health information by alternative means or to alternative locations. You must provide satisfactory explanation of how payments will be handled under the alternative means or locations.

Amendment: You have the right to request in writing that I amend your health information. Your request must explain the reason for amendment. I may deny your request under certain circumstances.

Right to a Copy of This Notice: You have a right to a paper copy of this notice and may request this at any time. If you received this notice electronically, you have the right to receive it in writing.

Breach of Private Health Information: You will be notified in the case of any breach of unsecured health information.

Questions and Complaints

If you want more information about my privacy practices or if you have any questions, please contact me. If you are concerned that I may have violated your privacy rights or you disagree with a decision I made about your health information, you may file a complaint in writing using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. I support your right to privacy and will not retaliate if you file a complaint.

Contact Information:
Therapist: Carolyn Mehlomakulu, LMFT-S, ATR-BC
Phone: (512) 660-7279 Fax #: (888) 972-5053
Address: 13706 Research Blvd, Ste 114, Austin, TX 78750

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CLIENT INSURANCE INFORMATION

Client Name: _____
Date of Birth: _____

1. Primary Insurance Company: _____
I.D. Number (on the front of the card):_____ Group #:_____
Policy Holder's Name:_____ DOB: ____/____/_____
Relationship to Client:_____
Behavioral/Mental Health Subcontractor (if applicable): _____

2. Secondary Insurance Company: _____
I.D. Number (on the front of the card):_____ Group #:_____
Policy Holder's Name:_____ DOB: ____/____/_____
Relationship to Client:_____
Behavioral/Mental Health Subcontractor (if applicable): _____

I hereby authorize Carolyn Mehlomakulu, LMFT-S, ATR-BC to share information to my insurance companies concerning the client's diagnosis and treatment. I hereby authorize Carolyn Mehlomakulu, LMFT-S, ATR-BC to provide treatment for me and/or my dependents and authorize payment for services.

I guarantee payment of all deductibles, copayments, coinsurance, and any services not covered by insurance. I understand that session rates, copayments, and coinsurance are set by the insurance company and are not negotiable with therapist.

I understand that insurance coverage of mental health services requires medical necessity and a mental health diagnosis. Insurance coverage cannot be guaranteed at the time of service.

I understand that it is the responsibility of the patient to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible. If I do not inform this office of the changes, I must pay for all fees not covered by your current or previous insurance companies.

_____ (*initial*) **Out of network insurance (if applicable):** I understand that for out-of-network services, I am initially responsible for all payment. I may be provided with a superbill at my request that can be submitted to my insurance company for possible reimbursement. I understand that reimbursement depends on my out-of-network benefits and is not guaranteed.

_____
Client/Guardian Print Name

_____ _____
Client/Guardian Signature Date

_____ _____
Therapist Signature Date

Carolyn Mehlomakulu, LMFT-S, ATR-BC
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CONSENT TO RELEASE & REQUEST CONFIDENTIAL INFORMATION

Client:_____ D.O.B._____

I (client/guardian) _____ hereby authorize Carolyn Mehlomakulu, LMFT-S (#201229), ATR (#12-188) to exchange confidential information regarding treatment with:

Contact Name & Relationship: _____

Address:_____

Phone, Fax, Email: _____

Information to be disclosed:

- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Assessment
- ☐ Other: _____

Purpose of this disclosure: _____
_____
_____

This authorization is in effect from _____ to _____, not to last more than one year. I understand that I may cancel or modify this authorization in writing prior to the expiration date. I understand that I have a right to receive a copy of this authorization.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Conservator Signature Date

_____ _____
Therapist Signature Date