Highland Village Mental Health & Wellness Center

2300 Highland Village Rd Ste 210
Highland Village, TX 75077
Phone 972-966-1079
Fax 972-767-0755

We are pleased to welcome you to HV Mental Health & Wellness Center!

Attached is our New Client Registration Package. Please complete these forms to help us maintain accurate contact information and medical records. If you printed these forms from our website, you may fax them to us at 972-767-0755 prior to your appointment or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your provider. We do appreciate and value the trust you have placed in us.

HV Mental Health & Wellness Center of Highland Village is dedicated to helping individuals of all ages deal with mental health and behavioral issues in healthy and effective ways. Our services include individual counseling in addition to all types of psychological and neuropsychological testing. We specialize in treating children on the autism spectrum, those with behavioral challenges, learning disorders, and other developmental delays. Our educational consultant provides tutoring and education advocacy for school-aged children and our Applied Behavior Analysis (ABA), and intervention program help improve skill deficits and decrease behavioral excess in children's behavior and skills in socially significant ways. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you we will do our best to give you total satisfaction.

We value highly the relationship with our clients. We especially value client feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other clients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Christina Della Nebbia, PHD

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Some testing fees** are due at time of visit
- **Completed Client Registration Package**
- **Driver's License or State Issued Photo ID**

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How did you find us?

- Family/Friend - Name: _____
- Insurance Provider List
- Internet Search
- Physician - Name: _____
- Other_____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: (____) _____Work Phone: (_____)_____

Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: _____

Did a doctor's office refer you to our office? ❑ Yes ❑ No

Name of Referring Doctor:

_____
(First and Last Name)

_____
(street address or city and state)

Phone: _____

Primary Care Physician: _____
(First and Last Name)

***Please bring a copy of any custody agreements with you to your child's appointment.**

If patient is a minor:

Parent/Guardian Information:

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Home Phone: (____) _____Work Phone: (_____) _____

Marital Status:_____ Employer: _____

Other parent/guardian Information:

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Home Phone: (____) _____Work Phone: (_____) _____

Marital Status:_____ Employer: _____

Responsible Party, if different from patient information above:
(statements will be addressed to the responsible party)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date of Birth: _____ ❑ Male ❑ Female

Phone: (_____) _____ Email: _____

Preferred Method of contact:_____

Relationship to patient: _____

Adult Emergency Contact:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____) _____ Alt. Phone: (_____) _____

Relationship to patient: _____

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

❑ Self Pay *(no insurance)* ❑ Patient IS the policy holder ❑ Patient IS NOT the policy holder

Primary Insurance Co.: _____ Policy Number _____

Secondary Insurance Co.: _____ Policy Number _____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know

NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

SUBSCRIBER INFORMATION (REQUIRED if patient is not the primary insurance policy holder):

Name: _____

Social Security #: _____ Date of Birth: _____

Employer: _____

PHARMACY INFORMATION:

Name: _____

Location (City and Intersection): _____

_____

Phone: (_____) _____

By signing below, I authorize Dr. Christina Della Nebbia's office to leave messages in reference to any items that assist in carrying out healthcare operations including appointment reminders and billing issues.

Home phone: ❑ Work phone: ❑ Email: ❑ -or list the Email address to use: _____

Please list any person(s) to whom your protected health information can be disclosed (e.g., spouse, parent, alternate caregiver, etc):

Name: _____ Phone Number(s): _____ Relationship: _____

Name: _____ Phone Number(s): _____ Relationship: _____

Name: _____ Phone Number(s): _____ Relationship: _____

Your signature will indicate your consent to this communication until you withdraw your consent in writing.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

I authorize the HV Mental Health & Wellness to perform diagnostic procedures and treatment as may be necessary for my treatment plan.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

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Patients, or legal guardians of patients under the age of eighteen, MUST sign and date all paragraphs below before medical care can be rendered.

Release of Medical Information

I authorize the release of medical information regarding my case to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, testing, insurance applications, and prescriptions. Your consent to this communication until you withdraw your consent in writing.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

Consent for Treatment

I hereby give my authorization and informed consent to receive psychological or therapeutic diagnostic and treatment services from **HIGHLAND VILLAGE MENTAL HEALTH & WELLNESS CENTER.** I further certify that I have the legal authority to authorize and consent to this treatment. Your consent to this communication until you withdraw your consent in writing.

Signature: _____Date: _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

Consent for Treatment of a minor (if applicable)

I certify that I am the: father, mother, managing conservator, legal guardian (circle one) of the above-named child. I hereby give my authorization and informed consent to receive psychological or therapeutic diagnostic and treatment services from **HIGHLAND VILLAGE MENTAL HEALTH & WELLNESS CENTER.** I further certify that I have the legal authority to authorize and consent to this treatment.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

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HIPAA Policies & Agreement for Psychological Services and Applied Behavior Analysis

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient 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 we provide you with a Notice of Privacy Practices (the notice) for use and disclosure of PHI for treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. Please read it carefully. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless I have taken action in reliance on it; If there are obligations imposed on us 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.

Confidentiality and Consent

The law protects the privacy of all communications between a patient 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 will obtain a written consent. 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 referred to as "PHI" in this document).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient 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 patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient. 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-patient 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 patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient 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 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 patient'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 patient 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 patient. 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

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in a professional record. I have transitioned to electronic records and administration processes using the professional tool, www.Therapyappointment.com. This includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on 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 or 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 desire a copy of your/your child's record, I will be happy to discuss it with you or provide a treatment summary. There will be a charge for records requests, unless another professional requests the records. Records can take up to 15 business days to be processed and require you to complete a written Authorization to Release Records. If you/your child are psychologically evaluated (tested), you will receive one copy of the evaluation without charge. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Requests for raw data will only be released to another mental health professional. I work with many physicians in this area and am happy to discuss treatment plans and updates; however, I will need a written Authorization to Release Records prior to consultation.

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Patient Rights

HIPAA provides you with several new or expanded rights regarding 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.

Minors & Parents

Parents under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I may request an agreement from the patient and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Psychological Services

I provide a variety of psychological services including individual, family, and group psychotherapy, psychological and neuropsychological testing, and applied behavior analysis. Psychotherapy helps with a variety of emotional and interpersonal problems. It intends to reduce or eliminate certain psychological symptoms, and to improve social, academic, or interpersonal functioning. Applied behavior analysis aims to improve behavior in socially significant ways.

Psychotherapy can have risks and benefits. Since therapy sometimes involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to lead to benefits such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

In the first session or two, I will evaluate your/your child's needs. At the end of that time, I will offer you some first impressions of what our work will include and a treatment plan to follow. If you have any questions about my procedures, we should discuss them whenever they arise.

Meetings

After the initial assessment, we will discuss your/your child's treatment plan. When follow up sessions begin, sessions last 45-50 minutes in duration. Occasionally, shorter sessions are held and will be billed at a lesser rate. Sessions may be held weekly or less often, depending upon your child's needs.

Contacting Me

I am in the office daily during the week, but I am not available to answer the phone when I am with a patient. When I am unavailable, you may leave a voicemail for non-emergency situations at (972) 966-1079. I will make every effort to return your call on the same day you make it. If an urgent situation arises after office hours, I am available by calling, and possibly leaving a message at, (469) 993-9167. However, if an emergency exists and you cannot wait for a return call, go to the nearest emergency room. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Please be aware that I strive to conduct clinical conversations only within sessions, not over the telephone or email.

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.

Privacy Practices (HIPAA)

By signing below, I acknowledge that I have read and understand Highland Village Mental health & Wellness Center (Dr. Christina Della Nebbia's) Notice of Privacy Practices.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

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Financial Policies:

Highland Village Mental Health & Wellness Center provides the following policies with the intent to build a clear and trusting relationship with the patient and their families. It is the hope that these policies will assist in avoiding misunderstandings concerning payment for professional services and provide the highest quality of care.

Please initial next to each policy listed below:

_____ **PROFESSIONAL FEES:** My hourly rate for an initial appointment is $183.00 and follow-up appointments are $180.00 for 60 minutes and $150.00 for 45 minutes. Other services are telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing other services you may request. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for the clinician's professional time, even if your clinician is called to testify by another party. Because of the difficulty of legal involvement, there is a $400.00 per hour fee for preparation and attendance at any legal proceeding. If you are insured through a deductible plan and your deductible has **not been met**, the office will collect the fee insurance companies allow. Deductible fees, co-insurance, and co-payment amounts are due at the time of service. If services are requested that are not covered by insurance, it will be the responsibility of the patient/parent to pay for these services. Educational Advocacy is $180.00 per hour.

_____ **PSYCHOLOGICAL TESTING:** There are two options for testing, Insurance and Private Pay. Insurance companies only pay for medically necessary testing. Insurance companies will not pay for educational testing. Private Pay testing is charged according to the type of testing, and you will be given a good faith estimate based on $150.00/hour for testing time, or educational testing. Additionally, you will incur a Protocol Fee based on the number of tests administered. You will be given a written notice of the protocol fee prior to testing, which is due by the day of testing. Any misplaced tests which have to be reissued and/or not returned on the day of testing or prior to testing will incur additional fees. Missed appointments, without 24-hour prior cancellation notice, will assess a "no-show/late cancellation" fee of $100.00. One copy of testing results will be provided free of charge; additional copies will incur a $50.00 fee.

_____ **NONCOVERED SERVICES:** If your insurance company does not pay for services rendered, those balances will become the patient's/parent's responsibility. Before receiving services, you must verify that your clinician is a participating provider for your insurance company. You can do this by calling the number on the back of your insurance card and having them verify that your clinician is in-network with your specific policy. Should it be true that the services are not in-network, you will be financially responsible for the out-of-network services rendered.

_____ **INSURANCE CHANGES:** It is your responsibility to provide the office with any and all changes to your insurance, billing address, and contact information. If new insurance information or any changes are not received within three (3) business days of your visit, you will be financially responsible for services rendered.

_____ **PAYMENT/CHILDREN OF DIVORCED PARENTS:** Co-payments, co-insurance, deductibles, and self-pay balances are due at the time services are rendered.

_____ **INSUFFICIENT FUNDS:** An account paid by check which is returned by the bank unpaid for any reason will be charged $60.00 in addition to the original balance. The office may also seek additional legal remedies under Texas law. Payment must be made by cashier's check, cash, or credit card.

_____ **PRIMARY INSURANCE:** We will file claims with your primary insurance companies which we are contracted. We do not file claims to secondary policies. Secondary claims filing will be the patient/client responsibility.

_____ **STATEMENTS**: We will send a statement to the billing address you provide. Payment is due upon receipt of the statement. If you have any questions or disputes about the validity of the balance, it is your responsibility to contact the Billing Department. Accounts not paid within 30 days of the statement date are considered past due. If you have difficulty paying your bill, payment arrangements may be made; however, it is your responsibility to contact the Billing Department and discuss a payment plan within 30 days to keep your account from being past due. If your account is over 60 days past due and you have not made payment arrangements, your outstanding balance will be sent to a collection agency.

_____ **MISSED APPOINTMENTS/LATE CANCELLATIONS WORK-IN APPOINTMENTS:** In order to meet treatment goals, it is essential that the patient arrive to the office 30 minutes prior to every scheduled appointment. Additionally, there are patients waiting to be scheduled for an appointment and when you fail to show up for your appointment or do not cancel 24 hours in advance, this slot cannot be filled with another patient needing services. Missed appointments, without 24 hour prior cancellation notice, will assess a "no call, no show/late cancellation" fee of $85.00. Patients arriving more than 20 minutes late to their appointment will be required to reschedule and will also incur a "no show/late cancellation" fee. If there are three (3) or more no shows or late cancellations, you must call the Office Manager to discuss the matter before another appointment may be scheduled. Work-in appointments for emergencies or other special circumstances will be available but must be discussed prior to the appointment. The same "no call, no show/late cancellation" rules will apply to these appointments. We will allow one (1) no call, no show/late cancellation without charge, but after that <u>any</u> reason an appointment is missed without 24-hour notice will be a fee of $85.00. If a testing appointment is missed or not cancelled within 24 hours, a fee will be received for this service in your name.

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_____ **MEDICAL RECORDS/FORMS AND LETTERS:** You must complete and sign an Authorization to Release Information/Records. There will be a $25 fee for records requests unless another professional requests the records. Most forms and letters will incur a $50 fee. Please allow 2-3 business days for all forms and letters to be processed. Disability paperwork will range from $75-150, depending on length and complexity of the form.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Highland Village Mental Health & Wellness when billed for all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Highland Village Mental Health & Wellness for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the doctor, or medical group, otherwise payable to me. I understand that my medical insurance carrier or payor of my medical benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
Regulations pertaining to Medicare assignment of benefits apply.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

Appointments and Cancellation Policy

In order for us to be available to you in a predictable manner, our services are provided on an appointment basis. We schedule our own appointments. On occasion and only when necessary, we need to change your scheduled appointment time, our office will contact you and provide personal notice. If you find that you will be unable to keep an appointment, we request that you give us **at least 24 hour notice. The charge for appointments cancelled without 24 hour notice will be $85.00.** This charge will be waived only in the event of an emergency.

No Show/Missed Appointment Policy

We understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please call us as soon as possible with at least a 24 hour notice. You can cancel appointments by calling our office at (972) 966-1079. You may also leave a voice message at our office phone number with at least a 24 hour notice. It is the patient's responsibility to arrive on time to their scheduled appointment to ensure that each patient is given their allotted appointment time and high-quality care is given. An appointment reminder call will be attempted one (1) business day prior to your scheduled appointment.

Emergencies

Since we provide services on an appointment-only basis, should you have an issue that cannot wait until our next available appointment, please leave us a voice message at (972) 966-1079 and we will attempt to return your call in the same day. If you have a life-threatening emergency, please go to the nearest emergency room, or call 911.

Please confirm you have reviewed the following policy in depth:

1. Your appointment must be cancelled with at least a 24-hour notice.
2. If less than a 24-hour cancellation is given, it will be labeled as a "No Show."
3. If you do not present to the office for your appointment, it will be marked as a "No Show."
4. After the first "No Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No Show" policy.
5. If you have two (2) "No Show/Missed" appointments within one calendar year, you will receive a warning phone call or letter and will be assessed an $85 no-show fee that will be withdrawn from your credit card on file.
6. If you have three (3) "No Show/Missed" appointments within one calendar year, you will receive a second $85 no-show fee.

I have read and understand the No Show/Missed Appointment Policy and understand that it is my responsibility to plan appointments accordingly and notify Highland Village Mental Health & Wellness Center appropriately if I have difficulty keeping my scheduled appointments.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

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Credit Card Guarantee of Payment

I understand that Highland Village Mental Health & Wellness Center will be billing me for therapy, evaluations, or psychological testing services. With this form, I give Highland Village Mental Health & Wellness Center permission to charge my credit card for any services that have not been paid by me within 24 hours of a missed therapy appointment or late cancellation, or within 60 days of billing. If services have not been paid within 30 days, Highland Village Mental Health & Wellness Center will notify me in writing of the outstanding payments.
I understand that Highland Village Mental Health & Wellness Center uses the credit card processing company Emdeon. On my credit card statement the charge will appear as it is coming from that company and not from Highland Village Mental Health & Wellness Center.

I understand that I must complete this form/agreement to be seen as a patient in this practice.

Patient Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____
_____

Type of Card (Circle One): Amex Discover Master Visa

Credit Card Number: _____

Security Code: _____ Expiration Date: _____/____

Signature: _____ Date: _____

Consent for Electronic Communication

Unencrypted email is not a secure form of communication. There is some risk that individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receiving emails from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

My email address is: _____@_____

Please check all that apply:
□ I consent and accept the risk in receiving information via email/text message. I understand I can withdraw my consent at any time.
□ I DO NOT consent to receiving any information via email/text. I understand that I can change my mind and provide consent later.
□ I consent to receiving information about office announcements via email/text.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

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CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION/TREATMENT

DEFINITION: Per the Texas Occupations Code, Chapter 111, **Telehealth service** means a "health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology."

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

In order for the telehealth service to take place, please go through and understand each item in this informed consent form. If you have questions, please do not hesitate to let us know and we will be more than happy to answer them for you.

1. I understand that I/my child am voluntarily participating in a treatment using telehealth technology rather than an in-person, face-to-face, visit.
2. I understand that this consultation/treatment will not be the same as an in-person, face-to-face, patient/health care provider visit due to the fact that I/my child will not be in the same room as my health care provider. My health care provider has explained to me how the video conferencing technology will be used in connection with this consultation/treatment.
3. I understand that I/my child may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telemedicine may include but are not limited to finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
4. The technology used by Highland Village Mental Health & Wellness Center, Microsoft Teams, is encrypted to prevent unauthorized access. Despite Highland Village Mental Health & Wellness Center's best efforts to protect the privacy of such information, security protocols could fail, causing a breach of privacy of confidential and Protected Health Information. Thus, I understand there are potential risks when using this technology, including interruptions, possible unauthorized access of medical information, and technical problems, e.g., equipment failure.
5. I understand that I have the right to withhold or withdraw consent to telehealth treatment at any time without affecting my/my child's right to future case or treatment nor risking the loss or withdrawal of any program benefits to which I/my child would otherwise be entitled.
6. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me/my child during the course of my/my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse or neglect; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
7. I understand that this document will become a part of my/my child's medical record.
8. I understand that I have the right to access my/my child's medical information and copies of medical records in accordance with Texas state law.
9. I understand that if I or my child need emergency mental health services, I should contact my local emergency room and/or call 911.
10. Video recordings may be taken of the telehealth treatment, only when video recording is already a part of standard clinical practices.
11. I understand that billing will be performed by Highland Village Mental Health & Wellness Center.
12. I have read this document carefully, and understand the risks and benefits of the telehealth treatment and have had my questions regarding the technology answered. I hereby consent to participate in telehealth treatment under the terms described herein.

Client/Patient Name :_____

Client/Parent/Guardian Signature : _____Date : _____/_____/_____

Printed Name: _____ Relationship to patient/client:_____

Highland Village Mental Health & Wellness Center

2300 Highland Village Rd Ste 210
Highland Village, TX 75077
Phone 972-966-1079
Fax 972-767-0755

Consent to Perform Services
Delegation of Services

Welcome to Highland Village Mental Health & Wellness Center. This form will provide information about our office and our services. Please be sure to discuss any questions or concerns with your clinician, Dr. Christina Della Nebbia, Ph.D.
All services are provided directly by the clinician stated above, or they could be delegated to a clinician under the supervision of Dr. Christina Della Nebbia. Clinicians that are under supervision are licensed psychological associates and doctoral-level practicum students. All clinicians under supervision have at least 3-10 years of training and supervised experience. They are closely supervised and delegation of services such as completing psychological testing and/or counseling are done under the license of Christina Della Nebbia, Ph.D. The licensed psychologist is responsible for the initial evaluation (interview/intake), ongoing care and development of the treatment plan. The psychological report is the responsibility of the licensed psychologist and counseling cases are reviewed on a weekly basis with all trainees. All clinicians on staff have received an extensive screening process prior to hiring to assure a high level of clinical expertise and competency. They also receive in-depth supervision and ongoing training.

By signing this form, I agree to allow a psychology professional in training to complete services under the supervision of a licensed psychologist. If any concerns arise, please address your concern to the supervising psychologist.

Clinicians on staff:

- Jason Smith, MS, LPA
- Cintia Martinez, MS, LPA
- Chanel De La Garza, Practicum student under the supervision of Dr. Della Nebbia
- Kylee Thomas, Psychometrist

Patient or Parent Name: _____

Signature: _____

Date: _____

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Adult Patient Information

Client/Patient Name: _____ Date: _____

1. Please describe the problem for which you are seeking help in the space below.

2. How would you describe the severity of the effects of the problem on you? Circle one.

   A Little Bit Moderately Quite Extremely

3. Please describe any prior counseling, therapy, or evaluation services received, including dates of services.

4. Please list any medications you presently take, and the dosage prescribed. Also, list any nonprescription medicine regularly taken.

5. Please describe any medical conditions for which you are being treated.

6. Please identify which of the following you use along with the frequency and quantity.

	Circle one	Frequency	Quantity
Alcohol	Yes / No		
Caffeine	Yes / No		
Drugs	Yes / No		
Nicotine	Yes / No		