Family Therapy Clinic of Louisiana, LLC
8480 Bluebonnet Blvd, Suite A,
Baton Rouge, LA 70810-2879

Policies and Financial Agreement, Privacy Notice, Consent for Treatment

The following document is comprised of the three sections listed below. Read each section carefully and complete all required information before your first visit. Please note that this document MUST BE COMPLETED, SIGNED, AND SUBMITTED before any evaluation or treatment can begin.

I. Office Policies and Financial Agreement

II. Notice of Privacy Practices (HIPAA)

III. Consent for Treatment

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SECTION I

Office Policies and Financial Agreement

A. OFFICE HOURS

Our office is open Monday through Friday from 9:00am - 5:00pm

B. PSYCHOLOGICAL SERVICES

• Initial Visit (60-90 minutes) - $180

• Therapy Session (60 minutes) - $150.00

• Therapy Session (45 minutes) - $120.00

• Therapy Session (30 minutes) - $70.00

C. SOCIAL WORK / LPC SERVICES

• Initial Visit (60-90 minutes) - $150.00

• Therapy Session (60 minutes) - $120.00

• Therapy Session (45 minutes) - $105.00

• Therapy Session (30 minutes) - $55.00

Telephone consultations will be charged according to the therapist’s normal hourly rate.

D. PSYCHOLOGICAL EVALUATIONS

• Psychological Screening - $320.00

• Fitness for Duty - $800.00

• Court Ordered/Mandated Evaluation - $800.00

• Pre-surgical evaluation - $640.00

• General Psychological Evaluation - $760.00 base ($100/hr for additional time needed)

• ADHD Evaluation (Teens to Adults Ages 15 & up) - $860.00

Time to complete evaluation and report is a MINIMUM OF 2 WEEKS, but not typically longer than 4 weeks.

Expedited results (i.e., less than 2 weeks) are available for a surcharge (15% of total evaluation cost, not billable to insurance).

There is a Supply Fee included in the cost of each evaluation, unless otherwise specified ($40, not billable to insurance).

E. SPECIAL ASSESSMENTS AND TESTING

• IQ testing - $340.00

• Achievement Testing - $340.00

• IQ and Achievement Testing - $540.00

• Career Interest Screening - $75.00

• Specific Psychological Assessment - $100.00 base ($100/hr testing)

F. FORENSIC SERVICES

• Consultation - $350.00 per hour

• Deposition - $350.00 per hour (must be paid in advance)

• Trial Testimony - $350.00 per hour

• Travel - $250.00 per hour

• Case Preparation and Review - $250.00 per hour

G. INSURANCE PRE-AUTHORIZATION

If using insurance, we will attempt to verify your insurance benefits prior to the completion of your first visit. However, it is ultimately your responsibility to call your insurance company before your visit and obtain a pre-authorization if required. Also note that pre-authorization from the insurance company does not necessarily represent a guarantee of payment from them.

H. LATE CANCEL OR MISSED APPOINTMENTS

Psychotherapists spend a relatively large amount of time with their patients, and there are a limited number of appointments available during a given week. Therefore, late cancellations and missed appointments can significantly interfere with the livelihood of a practice, and greatly reduce the ability to service patients in need. For this reason, there is a requirement that appointments be canceled with at least a 24-hour notice.

1. Appointments canceled with less than a 24-hour notice will be subject to a $50 LATE CANCEL FEE. Exceptions will be considered for significant illness or emergency situations.

2. Missed appointments or appointments canceled after the start time will be subject to a $75 MISSED APPOINTMENT FEE, with no exceptions.

I. PAYMENT FOR SERVICES

You will be responsible for payment of all charges incurred at the time of service. This will generally be your co-pay or co-insurance amount if using insurance. However, it may include the FULL INSURANCE ALLOWABLE CHARGE if your deductible has not been met, or the FULL NON-DISCOUNTED CHARGE if your benefits do not cover the service.

1. Rates are based on the scheduled time. Sessions that do not last the full scheduled time are still subject to the scheduled rate. Any reduction in a session rate is within the individual therapist's discretion.

2. If you are unable to make full payment of the account balance at the time of service, you should discuss payment options with the office manager and the clinician providing services. Failure to develop a payment agreement may subject your account balance to late payment charges. Should you fail to make payment in a timely manner and your account is sent to collections, you will be responsible for any additional charges incurred due to the collections process.

***You should always check in with the front receptionist prior to or after each visit to check account status and schedule any future services that may be necessary.**

J. PERSON RESPONSIBLE FOR PAYMENT

This is the person responsible for the patient's financial liability. This person should complete the information below and sign. If NOT signed by the person listed below, the patient will be held financially liable for their account.

Name: * _____

Date of Birth: * _____

Relationship to Client: * _____

SSN# (REQUIRED): * _____

Best phone # to contact: * _____

Address: * _____

_____

_____

_____

I understand and agree to the following:

1. Payment is due at the time of service

2. I accept full responsibility for the complete payment of my account.

3. I authorize payment of benefits to Family Therapy Clinic of Louisiana, LLC for services described.

4. My account is subject to the Late Cancel / Missed Appointment Policy stipulated above.

By entering my signature below, I acknowledge that I understand the above-stated office policies and the financial agreement with Family Therapy Clinic of Louisiana, LLC, and will comply with them in all respects.

PERSON RESPONSIBLE FOR PAYMENT _____

SIGNATURE: *

DATE: _____

K. CREDIT CARD ON FILE POLICY

These days, insurance benefits and coverage for services can be a very complicated business. We do our best to verify benefits and estimate a patient's responsibility prior to the service date. However, changing co-pays, unmet deductibles, uncovered services, and missed appointment fees can quickly raise a patient's account balance. In order to streamline our billing and payment system and prevent large balances for our patients, we have instituted a REQUIRED CREDIT CARD ON FILE policy at our clinic:

1. We will bill your insurance company first and upon their determination of benefits, we will charge your credit card only the amount listed as "patient responsibility". You are not required to use the credit card on file if you would prefer to use an alternative form of payment (e.g., cash, personal or cashier's check) and payment is made at the time of service.

2. Circumstances in which your card may be charged include, but are not limited to:

• Deductible and co-insurance amounts

• Any non-covered services and/or denial of services

• Missed or inaccurate co-payments

• Missed or canceled sessions without a 24-hour notice

3. If the credit card we have on file for you changes, we require that you notify us immediately by phone or email. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 fee if we are not able to run a new credit card within 7 days. Any new credit card will be subject to the financial policy listed here and may be used with the same authorization as the original card.

4. If there is a problem with your bill or claim and it is brought to our attention after your credit card payment processes, we will investigate the matter as quickly as possible. If it is determined that you have been overcharged, we will refund the overcharged amount to the same card in a timely manner.

Please complete the information below related to our Credit Card on File Policy:

Patient's Name: * _____

Patient's Date of Birth: * _____

Card Holder's Name: * _____

Relationship to Patient: * _____

Billing Address: * _____

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_____

Card Type: * ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

Card Number: * ______________________

Expiration Date: * ______________________

CCV# (last 3 digits on back): * ______________________

By entering my signature below, I:

1. Assign my insurance benefits to Family Therapy Clinic of Louisiana, LLC.

2. Authorize Family Therapy Clinic of Louisiana, LLC to keep my signature on file and to charge the credit card listed above for the services provided to the above named patient.

3. Acknowledge that I have read and agree to abide by the Payment Policy and Credit Card on File Policy for Family Therapy Clinic of Louisiana, LLC.

4. Understand that it is my responsibility to notify the office immediately of any changes to the above credit card information. Any new credit card will be subject to the Payment Policy and Credit Card on File Policy used with the same authorization as the original card.

5. Understand that this authorization is valid until such time that I cancel it through written notice to Family Therapy Clinic of Louisiana, LLC.

CARD HOLDER SIGNATURE: * ______________________

DATE: * ______________________

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SECTION II

Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Family Therapy Clinic, LLC must maintain the privacy of your personal mental health information and give you this notice that describes our legal duties and privacy practices concerning your personal mental health information. In general, when we release your mental health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal mental health information will be available for release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all mental health information we maintain. If we change our privacy practices, we will give you a revised copy of the privacy notice in written form either in person or by mail.

Once you have signed our consent form, we can use your mental health information for the following purposes:

1. Treatment. For example, a clinician may use the information in your mental health record to determine which treatment option best addresses your mental health needs. The treatment selected will be documented in your mental health records so that other mental health care professionals can make informed decisions about your care.

2. Payment. In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such mental health information onto an insurer in order to help receive payment for your mental health bills.

3. Mental Health Care Operations. We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your clinicians, mental health care staff, and other mental health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations. In addition, we may want to use your mental health information for appointment reminders. For example, we may look at your mental health record to determine the date and time of your next appointment with us, and then send you a reminder letter to help you remember the appointment. Or, we may look at your mental health information and decide that another treatment or a new service we offer may interest you. For example, we may contact a patient to notify them that we have a new research facility that offers new treatments. Furthermore, we many want to use information found in your mental health record, such as your name, address, phone number, and treatment dates, to contact you for fund-raising purposes. (FTC does not conduct fund-raising).

Please note that if you refuse to provide your consent to us, we may refuse to treat you.

Without your written consent or authorization, we can use your mental health information for the following purposes:

1. As required or permitted by law. Sometimes, we must report some of your mental health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries, or to respond to a court order.

2. For public mental health activities. We may be required to report your mental health information to authorities to help prevent or control disease, injury, or disability. This may include using your mental health record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

3. For mental health oversight activities. We may disclose your mental health information to authorities so they can monitor, investigate, inspect, discipline, or license those who work in the mental health care system or for government benefit programs.

4. For activities related to death. We may disclose your mental health information to coroners, mental health examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

5. For organ, eye, or tissue donation. We may disclose your mental health information to people involved with obtaining, storing, or transplanting organs, eyes, or tissue of cadavers for donation purposes.

6. For research. Under certain circumstances, and only after a special approval process, we may use and disclose your mental health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

7. To avoid a serious threat to mental health or safety. As required by law and standards of ethnical conduct, we may release your mental health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's mental health or safety.

8. For military, national security, or incarceration law enforcement custody. If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your mental health information to the proper authorities so they may carry out their duties under law.

9. For workers' compensation. We may disclose your mental health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

10. To those involved with your care or payment of your care. If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your mental health bills, we may release important mental health information about you to those people. The information released to these people may include you location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your mental health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or mental health status. We may allow you to agree or disagree orally to such release, unless there is an emergency.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your mental health information. An authorization is different than consent. One primary difference is that unlike with consents, a provider must treat you even if you do not wish to sign an authorization form. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to Erich G. Duchmann, Ph.D.

Your Mental Health Information Rights:

You have several rights with regard to your mental health information. If you wish to exercise any of the following rights, please contact Erich G. Duchmann, Ph.D. Specifically, you have the right to:

1. Inspect and copy your mental health information. With a few exceptions, you have the right to inspect and obtain a copy of your mental health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your mental health information.

2. Request to correct your mental health information. If you believe your mental health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your mental health information should be changed. However, if we did not create the mental health information that you believe is incorrect, or if we disagree with you and believe your mental health information is correct, we may deny your request.

3. Request restrictions on certain uses and disclosures. You have the right to ask for restrictions on how your mental health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or mental health care operation activities. Or, you may want to limit the mental health information provided to family or friends involved in your care or payment of mental health bills. You may also want to limit the mental health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.

If you receive certain mental health devices, you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the mental health device.

4. As applicable, receive confidential communication of mental health information. You have the right to ask that we communication your mental health information to you in different ways or places. For example, you may wish to receive information about your mental health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosures of your mental health information. In some limited instances, you have the right to ask for a list of the disclosures of your mental health information we have made during the previous six years, but the request cannot include date before April 14, 2003. This list must include the date of each disclosure, who received the disclosed mental health information, a brief description of the mental health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, mental health care operations, our directory, nation security, law enforcement/ corrections, and certain mental health oversight activities.

6. Obtain a paper copy of this notice. Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.

7. Complain. If you believe you privacy rights have be violated, you may file a complaint with us and with the federal Department of Mental Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact who will provide you with the necessary assistance and paperwork.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact Erich G. Duchmann, Ph.D. at 225-292-0155.

This Notice of Mental Health Information Privacy is effective April 14, 2003.

I consent to allow Family Therapy Clinic of Louisiana, LLC to use or disclose my protected health information for treatment, payment, and health care operations as indicated below:

Health Information Use: *

☐ No restrictions

☐ I request restrictions to the use of my health information as listed below:

Restrictions: ____________________

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SECTION III

Consent for Treatment

I understand that:

• My participation in outpatient therapy at Family Therapy Clinic of Louisiana, LLC is strictly voluntary.

• All information obtained in therapy, including psychological assessment data, is confidential and can only be released with written consent. Exceptions to this legal safeguard are:

1) If I am a danger to myself or others

2) Records are subpoenaed by a court of law

3) The therapist discovers abuse or neglect of any child or an adult who cannot physically or mentally protect themselves

• The data from psychological assessment procedures that are performed may be used for research purposes and in the event of such use, I have been assured that my identity will remain totally anonymous in any research database that is derived from review of patient records ad Family Therapy Clinic of Louisiana, LLC.

Any questions that I have may be answered by my therapist or by contacting Erich G. Duchmann, Ph.D. at (225) 292-0155.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Family Therapy Clinic of Louisiana, LLC, and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent for the evaluation and/or treatment to cover the entire course of treatments for my present condition(s) and any future condition for which I seek treatment at this facility.

PATIENT SIGNATURE: * _____

DATE: _____

For patients who are under the age of 16, we ask that a parent or legal guardian also sign (ENTER N/A IF NOT APPLICABLE).

SIGNATURE OF LEGAL GUARDIAN: * _____

DATE: _____