Mariposa Therapies, PLLC

Confidential Client Information

Today's Date: _____ Your Date of Birth:_____

Your Name: _____

Address/City/Zip: _____

Phone Number(s) *where we may leave a message for you*:

1. _____ 2. _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Your Occupation: _____

With whom do you live? _____

Do you have children? ____ If yes, list gender/age: _____

Who referred you? _____

Name of Primary Physician: _____

What medications do you take regularly? _____

_____

Are you seeing a psychiatrist? ____ If yes, who? _____

Please list any chronic medical problems: _____

_____

If you have ever been in counseling, substance abuse treatment, or hospitalized for a mental condition, please give a brief explanation as well as approximate dates.

_____

_____

_____

_____

Briefly describe why you are here and any particular goals you have for therapy.

Is there anything else you would like Tonya to know?

Consent for Treatment
With my signature below I consent to begin counseling sessions with Tonya Walton, LCSW.

Signature Date

Insurance Authorization
Skip this section if we will not be billing insurance.

Insured's Name (if not patient)		Plan Name			
Insured's Employer		Insured's ID #			
Group/Policy #		Contact Number on Card			
Patient's Relationship to Insured		Insured's Date of Birth		Insured's Gender	

I authorize the **release of any medical or other information necessary** to process health insurance claims. Further, I authorize **payment of medical benefits** to Mariposa Therapies, PLLC and Tonya Walton, LCSW.

Signature Date

Office Policies for Tonya Walton, LCSW

Confidentiality
Information you share with me in treatment is confidential. Unless you instruct me otherwise, I may discuss your progress in our sessions with other licensed healthcare providers who provide you with services or are otherwise involved in your care in order to effectively coordinate treatment. More information about confidentiality is in my Notice of Privacy Practices.

The following are legal exceptions to your right to confidentiality:

1. If I have reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this.
2. If I believe that you are in imminent danger of harming yourself or another person.
3. As otherwise required by law.

Treatment
You have the right to ask questions about anything that happens in therapy. I welcome feedback about our progress and your perceptions. You are free to leave therapy at any time. You are in charge of your treatment, which includes communicating honestly about your needs and preferences, providing feedback, and asking questions when you do not understand. You are responsible for arriving on time for your appointments. Sessions last 43-57 minutes. If you are late, our session will still end on time in order to accommodate other clients.

Crisis Situations
I am not available for emergency phone calls. If you experience an emergency, please call the Austin/Travis County Crisis Hotline at 512.472.4357 or Williamson County's Bluebonnet Trails at 800.841.1255. If you fear that you may cause harm to yourself or another person, immediately call 911 or go to the nearest hospital emergency room.

Complaints
If you are dissatisfied with my services, I ask that you discuss your concerns with me. I will take this feedback or criticism seriously and treat it with care and respect. If you believe I have been unwilling to listen or that I have behaved unethically, you may report your grievance to the Texas State Board of Social Worker Examiners, PO Box 141369, Austin, Texas 78714-6718 or call 800.942.5540.

Payment
My fee for 50-minute counseling sessions is $120. I charge $50 for completion of disability paperwork. I accept a limited number of insurance policies. If I am not a participating provider for your plan and the plan covers out of network providers, I will provide you with a receipt and billing codes so you can submit for reimbursement. If private insurance is paying for your treatment, I must provide your carrier with a diagnosis. Some insurance companies require detailed treatment information as well. You may wish to consider and discuss with me the possible outcomes of filing insurance claims.

You are responsible for verifying that your insurance covers me as a provider as well as the amount of deductible and copay. If pre-authorization is required, you must provide the authorization code at the first appointment. I will bill your insurance company for each visit. If for any reason an insurance claim is denied, you are ultimately responsible for payment.

Unpaid account balances may be sent to collections and will incur a surcharge of 40% of the original account balance.

_____ Initials

Cancellations and Missed Appointments

- **You are required to provide notice at least 48 hours in advance to cancel or reschedule an appointment. If you fail to provide sufficient notice or fail to show up for an appointment, for any reason, you will be charged $50. You, not your insurance company, are responsible for payment of this charge. Payment is required prior to scheduling a follow-up appointment.**
- **Courtesy reminders for appointments may or may not be issued by my office. You are responsible for remembering your appointment time.**

Acknowledgement

I have read this information, asked any questions I needed to, understand it, and agree to it. Further, by signing below I acknowledge that I have been given the opportunity to read and receive a copy of the Notice of Privacy Practices.

_____

Printed Name

_____ _____

Signature Date

Payment Authorization

Name on Card: _____

Card Number: _____ -- _____ -- _____ -- _____ Exp. Date: ____/____

Security Code: _____ Billing Zip for Monthly Card Statements: _____

I authorize Mariposa Therapies, PLLC to charge this credit card for copay, co-insurance, or fees toward patient portion per insurance company explanation of benefits, if applicable.

By signing, I authorize Mariposa Therapies, PLLC to charge $50 if I fail to show up for a scheduled appointment or if I cancel an appointment with less than 48 hours notice, unless other arrangements have been made with the office.

Unless arrangements have been negotiated with this office, any outstanding account balance not paid within 30 of notification by this office will automatically be charged to this card.

Card Holder's Signature: _____ Date: _____

Electronic Communications

State and federal government regulations as well as a professional Code of Ethics require that we keep your Protected Health Information private and secure, and we indeed want to do so. Email and texting are very convenient ways to handle administrative issues such as scheduling and receipts, but email and texts are not 100% secure. Some of the potential risks you might encounter if you agree to use of email and text include:

- Misdelivery to an incorrectly typed address or phone number.
- Email account being archived, giving a third party access to email content.
- Email providers (e.g. Gmail, yahoo) keep a copy of each email on their servers, where it might be accessible to their employees.
- Phones and laptops can be lost or stolen.

For these reasons, we will not use email to discuss clinical issues (i.e. the important things you discuss with the therapist in the office).

If you are comfortable doing so, we are happy to use email to handle administrative issues like scheduling and billing. Tonya may even use email to send resources to you, such as a book title, link to a website, or notice of a class.

If you are not comfortable with these risks, we will communicate by phone.

We do not connect with clients via social networking sites such as Facebook or LinkedIn. Please don't take this personally. It is to protect your privacy.

Please indicate your preference about email and texting and sign below. If you choose to communicate via text and/or email, we ask that you initiate contact by texting 512.368.0985 or emailing hello@mariposatherapy.com. This will help to minimize the risk of misdirected communication.

Initial your choice.

_____ I consent to the use of email and texting.

_____ I DO NOT consent to the use of email and texting and prefer phone communication.

If given, consent will expire two years after our last appointment and may be revoked at any time upon your request.

_____
Printed Name

_____ _____
Signature Date