Lori T Candrian, M.S., L.P.C. 105 N. Gordon, Suite 202, Alvin, TX 77511 Phone: 281-585-0000 Fax: 281-585-0080

Special Instructions: While you may have registered online, please download, print, complete and bring the following forms to your first appointment. These forms contain required information and ask for your signature.

Please note, I accept CASH, CHECK and CREDIT CARDS, for payment not covered by EAP or Insurance.

OFFICE PRACTCES AND POLICIES

The information below is intended to inform you about office practices and policies. Because your relationship with your therapist is based on confidence and trust, it is important that you be fully informed of some of the key elements of that relationship. Though the following list may be daunting, please be assured I will be happy to discuss these policies in detail so that you may feel comfortable with them. This form also serves to document that these policies have been discussed. I will be happy to answer any questions you may have and provide a copy for you to keep.

I have an independent private practice, and while I share office space with other mental health practitioners, each clinician represents an independent private practice.

Emergencies: Messages can be left on my voice mail by calling 281-585-0000 ext. 1. Calls are returned between 8:00 a.m. and 6:00 p.m., Monday-Friday. I make every effort to return calls within 24 hours. After hour calls are reserved for urgent situations ONLY. If you have an ***urgent*** situation and must speak with me immediately, please leave a message on my voice mail and state it is urgent. I will call you back as soon as possible. I recommend that you dial 911, go to your local emergency room or contact your primary care physician in life threatening emergencies. **Do not email or text regarding emergencies.**

Goals of Therapy: Goals of treatment will be developed in discussion between Lori Candrian and you. Therapy is a joint effort between the therapist and the client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, consistent attendance, work outside of therapy (assignments) and other life circumstances such as interactions with family, friends, and other associations. It is important to review the work toward meeting these goals and make revisions as needed.

Risk of Treatment: Medicines often have their side effects; in a similar manner there are risks associated with seeking psychological services. For example, as you begin treatment you may become more anxious or experience increased temporary family or relationship conflict. It is normal to feel somewhat reluctant to talk about personal problems with someone you have just met, but this feeling tends to decrease as you become more familiar with your therapist. Although most people report benefits from psychotherapy, a minority feel their conditions worsened as a result of treatment.

Length of Treatment: The length of treatment will be determined in discussion between Lori Candrian and you. Insurance benefits may impact length of treatment. You may withdraw from treatment at any time. If you elect to stop treatment, I will, if you wish, provide you with the names of other practitioners with whom you may want to continue treatment.

Appointment Times: Appointment times are limited. Sessions are 38 to 52 minutes or 53 to 60 minutes if allowed by insurance. The first majority of the session is spent addressing the presenting problem with the last 5 minutes used to summarize the session and plan for the future.

Missed Appointments: Appointment times are reserved for YOU. If you do not keep your appointment or do not cancel 24 hours in advance, **YOU will be charged a $75.00 No Show/Late Cancellation fee which is due prior to or at the time of your next appointment.** You are responsible for rescheduling missed or cancelled appointments. If you miss two consecutive sessions without informing or contacting me, I will assume that you wish to terminate services. You may terminate services any time by notifying me.

Fees and Payment Information: My professional fee is $160.00 for 60 minute initial psychiatric diagnostic evaluation interview, $140 for 53 to 60 minute session, $120.00 for 38-52 minute session, $80.00 for 16 to 37 minute session. Different fee arrangements have been negotiated with some insurance companies. Payments for services or insurance co-payments/deductibles are discussed at your first session but you are encouraged to contact your insurance plan. Occasionally, copays/deductibles are not available until after the first billing and you are responsible for any difference. The following fees are paid by the client and cannot be billed to your insurance/EAP: $75.00 for No Show/Late Cancellation, $200.00 for Letter of Treatment Summary for Legal Purposes, $100 for Letter of Treatment Summary for educational or other non-legal purposes, $50.00 plus $1.00 per page over 10 pages for Copy of Treatment

Records (except for continuity of care), $30.00 charge for returned checks, $30.00 per 15 minutes for after hours, non-emergency phone consultation. See below for fees associated with court appearances.
Payment may be by CASH, CHECK OR CREDIT CARD and is due <u>at the time services are rendered</u>. *I reserve the right to seek collections for delinquent accounts. I will work with you in every way possible to avoid such an event.*

<u>Confidentiality:</u> The information you provide to Lori Candrian and to those under her supervision is confidential and will generally be released to others only with your written consent. However, I am required by law to disclose confidential information even without your consent in certain circumstance. These circumstances include but are not limited to the following: If I consider you to be a danger to yourself or others; if you are a minor, elderly or have a disability and I believe you are a victim of abuse; if you report to me that a previous helping professional engaged in a sexual relationship with you; if you are involved in any suit or court proceeding affecting the parent/child relationship; if you file suit against the therapist for breach of duty and if court order or other legal proceeding or statue requires disclosure. If you chose to file insurance or work with a managed care company or EAP information regarding your treatment, diagnosis, and the specified issues for which you have come to treatment are available to the insurance company, managed care company or EAP. Health insurance companies often require that I diagnose your mental conditions and indicate you have an "illness" before they will agree to pay for services. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I summit it to the health insurance company. Any diagnosis made may become a part of your permanent insurance records. Once the information is turned over to the insurance company, managed care company or EAP, I have no control over how the information may be used. You have the opportunity to discuss with me any questions you may have on the limits of confidentiality. Please also refer to the HIPAA Regulations.

<u>Court Appearances</u>: My focus in providing psychotherapy is on treatment and on healing. It is not my intention to become involved in cases that require my testifying in court. However, should this service be needed, forensic or legal work in terms of paperwork, research, preparation and calls the following rates will apply. Preparation for court including gathering records and phone calls with client/attorney will be billed at a rate of $200 per hour, plus additional fees listed above for records or treatment summaries. Court appearances will require a $1000.00 retaining fee to be paid a week prior to the court. The fee for court appearances will be billed for a minimum of a 3 hour time period at $600.00 plus mileage (0.55 per mile) and travel expenses such as hotel if needed. Any court appearance over 3 hours will then be billed at $200.00 per hour plus the additional costs listed previously. Any unused funds from retaining fee will be reimbursed. **All fees associated with Court Appearance must be paid in cash or cashier's check.**

<u>Management of Records</u>: In the unlikely event of this provider's death I do give permission for any and all records to be turned over to the care and responsibility of Samantha R. Candrian, BS, daughter of Lori T. Candrian, MS, LPC. If this provider and her daughter were to die together, I give permission for any and all records to be turned over to colleague Stephanie K Wilkes, LCSW, PLLC immediately. These records will be kept according to the guidelines of The Texas State Board of Examiners.

<u>Social Media</u>: Including but not limited to Facebook, Instagram, and Twitter may be used by therapist as a tool for marketing services and disseminating information. Social media of any kind are **not** secure in terms of privacy and confidentiality. Therapy is not provided via social median. Private message delivered via social media will not be acknowledged. Emergencies delivered through social media will not be acknowledged. If you have an emergency, do not contact me through social media, text, or email, call 911 or go to the nearest emergency room. Call the office and leave a message with details of your emergency.

<u>I have read and agree to the above Office Practices and Policies:</u>

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

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PROFESSIONAL STATEMENT

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a licensed professional counselor in the state of Texas. I hold a Master of Science degree in Guidance and Counseling from Texas A&M University-Commerce. I primarily see individuals age 10 through adult with personal growth issues or mental health disorders I also provide couples and family counseling. A variety of therapeutic techniques are used to connect with each individual including Cognitive Behavioral Therapy, Client Centered Therapy, Psychoeducation, Play Therapy, Art Therapy, and other techniques as needed.

I have been a professional counselor since 1990. I accept clients in my practice who I believe have the capacity to resolve their own problems with my assistance or guidance. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. However, self-awareness and self-acceptance are goals that sometimes take a long time to achieve. Some clients need only a few counseling sessions to achieve these goals, while others may require more. As a client, you are in complete control and may end our counseling relationship at any point. I will be supportive of that decision and provide you names of other practitioners with whom you may want to continue treatment. If counseling is successful, you should feel that you are more able to face life's challenges in the future with less stress and difficulties.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you will arrange with me. It would not be appropriate for you to invite me to socials gatherings or ask me to relate to you in any way other than in the professional context of our counseling sessions. Your needs will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your issues or concerns. You will learn about me as we work together during our counseling experience. However, it is important for you to remember that you are experiencing me in my professional role.

I assure that my services will be rendered in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Professional Counselors in Texas at 1-800-942-5540.

If you have any questions, feel free to ask. Please sign and date this page. You may request a copy for you to keep for your records.

CLIENT/COUNSELOR CONTRACT AND ACKNOWLEDGEMENTS

I _____ commit to enter into a counseling relationship. In doing so I am personally committing to do the following:

A. Keep all scheduled appointments unless circumstances beyond my control prevent my attendance. I will be responsible for rescheduling missed appointments.
B. Participate in the counseling process honestly and to the best of my ability.
C. Complete any self-help assignments that I have agreed to carry out.
D. Apply any skills that I have gained to improve the quality of my life and the life of those around me.
E. I will notify my therapist of any significant changes or problems that may impact my work in therapy.

Acknowledgement: I have read and understand the Professional Statement and the Client/Counselor Contract. I recognize that I have the opportunity to discuss any questions I may have.

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

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NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

NOTICE DESCRIBLES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This handout is a shorter version of the full, legally required NPP which you may request to review for more information. However, I can't cover all possible situations so if questions arise please talk to me about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign the form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Of course I will keep your health information private but there are some times when the laws require me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. Ask me to arrange how to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post the new version in the waiting area and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact Lori T. Candrian (Privacy Officer) who can be reached by phone or mail at the above number and address.

For more information about HIPAA or to file a complaint: The U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201. you may email OCR at OCRMail@hhs.gov or call the U.S. Department of Health and Human Services, Office for Civil Rights toll-free at: 1-800-368-1019, TDD: 1-800-537-7697. The effective date of this notice is January 9, 2020.

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CONSENT AND DISCLOSURE

(Protected health information for treatment, payment or health care operations)

This form is an agreement between you, _____ and Lori T. Candrian, M.S., L.P.C. When I use the word "you" below, it will mean you and your child, relative, or other person if you have written his or her name here:

_____

When I examine, diagnose, treat or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information and send to others. The Notice or Privacy Practices explains in more detail your rights and how I can use and share your information. Please read the Notice of Privacy Practices before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I CANNOT treat you.

In the future I may change how I use and share your information and so may change my Notice or Privacy Practices. If I do change it, you can get a copy from me by calling me at the above number or by asking me in person.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signatures for Consent to use and disclose your protected health information for treatment, payment or health care operations and verification that Notice of Privacy Practices – Brief Version was received:

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

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CONSENT TO RELEASE TO PSYCHIATRIST OR PRIMARY CARE PHYSICIAN

Client Name:_____DOB:_____

I give my permission for Lori T. Candrian, M.S., L.P.C. to disclose my protected health information to:

_____

Address: _____
Phone: _____Fax:_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____ RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described below. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____(initials) I DO NOT wish treatment information to be given to my Primary Care Physician.

_____(initials) I DO NOT wish treatment information to be given to my Psychiatrist.

_____ _____
Signature of Individual or Individual's Legally Authorized Representative Date
Printed Name of Legally Authorized Representative (if applicable):
_____
If representative, specify relationship to the individual: ___ Parent of minor___ Guardian___ Other_____

To: _____

From: Lori T. Candrian, M.S., L.P.C. _____ Date:_____
Information to be disclosed:
I am currently seeing the patient named about for:
_____ Individual Therapy _____Marital Therapy _____Family Therapy

The patient's initial diagnosis is: _____
I have requested that the patient see you for:
_____ Evaluation for psychotropic medication
_____ Medication Management issues
_____Physical Examination or Lab work_____

Other Concerns/Issues:
_____
_____
_____
_____

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MEDICAL INFORMATION

Client Name: _____ Date: _____

Previous Mental Health Treatment: _____Yes _____No

Explain: _____

Referring Physician/Psychiatrist: _____

Date of Last Physical: _____

Major Illnesses/Diagnosis: _____

_____

Medications: _____

_____

Relevant Family Information: _____

_____

Are you allergic to any medications or have you ever experienced adverse reactions to any medications?
_____Yes; Describe: _____
_____No

Are you currently under the care of a physician for any medical problems, or are you experiencing any medical problems that you are concerned about?
_____Yes; Describe: _____
_____No

Have you been treated for any significant medical problems in the past?
_____Yes; Describe: _____
_____No

Client Signature: _____ Date:_____

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ASSIGNMENT OF BENEFITS/REQUEST FOR DISCLOSURE/MERGENCY CONTACTS

Client Last Name: _____

Client First Name: _____

Client DOB: _____

Release of Information: I authorize the release of any medical information, including diagnosis, or other information necessary to process this claim for services. I realize Lori T. Candrian, M.S. L.P.C. may be required to release parts of my record and/or discuss my case with my insurance carrier or authorized insurance review committee to receive payment, obtain additional authorization for services, or for case audit. I also request payment of government benefits either to myself or Lori T. Candrian, M.S., L.P.C.
Client or Authorized Person's Signature_____

Assignment of Benefits: I authorize payment of medical benefits to Lori T. Candrian, M.S., L.P.C. for services provided. I understand I am financially responsible for charges not covered by insurance (co-pays. percentages, deductibles, no-show fees when applicable, or non-payment due to failure to provide information regarding changes in insurance coverage. I understand that Lori T. Candrian, M.S., L.P.C. reserves the right to seek collections for balances due by me.
Insured's or Authorized Person's Signature_____

PATIENT REQUEST FOR DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request confidential communications of Public Health Information (PHI) be made by alternative means such as sending correspondence to the individual's place of employment instead of their home. All efforts will be made to comply with these requests.
I wish to be contacted in the following manner:
Detailed messages may be left on answering machine, voice mail or with a person at the following number(s). Please indicate if home, cell, work or other number.

Name and number ONLY may be left on answering machine, voice mail, or with a person at the following number(s). Please indicate if home, cell, work or other number.

Written Communication may be mailed to my home address: _____YES_____NO
Electronic Communication via email: _____YES_____NO
Email:_____
Appointment Information may be texted to the cell number on record: _____YES ____NO
Information may be faxed to:_____

In case of emergency please contact:
Name_____Phone_____Relationship_____
Client or Authorized Person's Signature:_____**Date:**_____

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APPOINTMENT REMINDERS, ONLINE SCHEDULING, TEXTING

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Text Messaging:

1. Therapist chooses to use text messaging for emergency/illness cancellation of sessions. By signing below I agree to this method for cancellation by Therapist.
2. Text messaging will be used for scheduling purposes only using 281-435-9631. Therapist will accept cancellation or rescheduling a session via text messaging but you must identify yourself with first name and last initial as client numbers are not saved on cell phone. (Late cancellation/now show will still apply).
3. Text messaging is not appropriate for clinical issues or crisis interventions. By signing below, I recognize that the Therapist ***will not*** respond to clinical or crisis situations via text message. There are options for crisis situations (call 911 or go to nearest emergency room) or clinical issues (call the office and leave a detailed voicemail. Do not call and/or leave a voicemail on cell number which is for texting regarding scheduling purposes ***only***.
4. _____(initials) **I *decline* to use text messaging for scheduling purposes.**

Client or Authorized Person's Signature: _____

Date:_____

Counselor Signature:_____

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Client Name: _____Date of Birth: _____
Parent/Guardian Name: _____

I, _____.authorize Lori T Candrian, M.S. L.P.C. to keep my signature on file and to charge my credit/debit card for the recurring charges: Please initial.

_____Co-pay/Co-Insurance in the amount of $_____

_____Private Pay in the amount of $_____

_____I agree for additional charges should insurance EOB reflect a different amount due.

I, _____ authorize Lori T Candrian, M.S., L.P.C. to keep my signature on file and to charge my credit card for the amount of $75 for no shows and late cancellations without 24 hour notice. (This fee will only be waived one time.) This policy supports the reservation of each appointment and the smooth running of office operations.

A receipt for any charges will be given to me via:
_____ (initials) my email address_____
_____ (initials) printed

I understand that this form will be renewed in January of each calendar year and is valid for one calendar year unless I cancel authorization in writing. Credit card information will be kept via electronic file with TherapyAppointment.com

All information includes sufficient funds, expiration date, valid card number and etc.

By my signature below, I guarantee that I am the account holder and that I agree to the above terms.

Card holder Name: _____

Billing Address for Credit/Debit
Card: _____

Type of Card: _____Visa _____Master Card _____Discover _____Amex

Credit/Debit Card Number: _____

Expiration Date: _____ 3 digit code on back of card _____

Card Holder Signature: _____ Date: _____