

### **Appointment Reminders and Online Scheduling**

You may schedule appointments online at your own convenience, but you must first establish an account with Diana Bigham, LMFT. Please complete the information below and follow the directions on how to schedule your appointments online. Please keep in mind that cancelling appointments within 24 hours may result in a fee of \$25. Two “no-shows” may result in termination of therapy services. If you do not wish to use the online scheduling feature, you may continue to schedule appointments in person or by phone.

My office follows the Keller Independent School District (KISD) bad weather policy. If KISD closes, our appointment will be canceled. If it is delayed and your appointment time was set for a time after school re-opens, we will resume our scheduled meeting time. For example, if KISD opens at 10 and your appointment is at 10:30am, we will still meet. Appointments before 10 would be canceled.

*To schedule an appointment online, go to [www.dianabigham.com](http://www.dianabigham.com) and click on “Schedule an Appointment.” Once you click on the green button to schedule an appointment, you will have the option to enter your login name and password that you created below.*

You also have the option to receive a reminder of your appointments via email, text to your cell phone, or a computer generated message to your home phone the day before your scheduled appointments. Please enter your preferred mode of appointment reminders.

Client’s Legal Name: \_\_\_\_\_  
(If client is a minor, name of parent or guardian)

Email Address: \_\_\_\_\_

Requested Login Name: \_\_\_\_\_ Requested Password: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please select ONE of the options below to receive your appointment reminders:

- Via email to email address listed above.
- Via text to cell phone listed above. (Normal text message rates apply. If you do not have a carrier listed above, please select another way to receive reminders).
- Via automated phone message to the home phone listed above.
- None of the above. I’ll remember my appointments. Missed appointment fees 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.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**Credit Card Authorization Agreement**

I, \_\_\_\_\_, *authorize* Diana Bigham, LMFT to charge my  
(Cardholder's Printed Name)

VISA    MASTER CARD (circle one) indicated by the account number ending in

\_\_\_\_\_ for the following services:  
(the last 4 numbers on the card)

- For sessions of counseling
- For Missed Visits (No Shows & Late Cancellations [less than 24 hours notice])
- For Unpaid Balances over 45 days
- For Insufficient Funds (including the fee and a penalty charge of \$25.00)
- For Books that are purchased or borrowed from my therapist

I understand that my signature and initials indicates that I am giving my permission for my card to be activated for the above services as they occur. The account information will be stored securely electronically and not shared with anyone else and not recorded on a written form. I will need to respond in writing to revoke this authorization or change the authorization. I understand that I will be held responsible for any charges and/or fees if the authorization of this card is declined. I understand that it is my responsibility to advise you if I close this account.

\_\_\_\_\_  
(Signature of Cardholder)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Client)

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I, \_\_\_\_\_, *decline* Diana Bigham, LMFT to charge my credit card.  
(Cardholder's Printed Name)

\_\_\_\_\_  
(Signature of Cardholder)

\_\_\_\_\_  
(Date)

**Diana Bigham, MA, LMFT-S, RPT-S**  
620 Stoneglenn Drive, Suite B Keller TX 76248 Ph. 817-562-8800

**Permission for Minors to Participate in Therapy**  
**(with Statement of Guardianship of Minors)**

I, \_\_\_\_\_, hereby declare that  
Printed Name of Parent/Guardian

\_\_\_\_\_ is/are under my  
Printed Name of Child/Children

guardianship and I am responsible for his/her/their physical, emotional, spiritual, and psychological well-being. As such I give my permission for this/these child(ren) to participate in therapy with **Diana Bigham, MA, LMFT.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship to Child(ren)

\_\_\_\_\_  
Date

**Parent Intake Form for Minor**

Child's Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**Present Concerns:**

Check any of the following behaviors that your child currently displays:

- |   |  |
|---|--|
| <input type="checkbox"/> Cries easily   | <input type="checkbox"/> Withdrawn   |
| <input type="checkbox"/> Wishes he/she was dead   | <input type="checkbox"/> Constantly seeks approval                                     |
| <input type="checkbox"/> Worried/anxious no matter where he/she is                                  | <input type="checkbox"/> Has trouble paying attention                                  |
| <input type="checkbox"/> Has sleeping problems  | <input type="checkbox"/> Has trouble sitting still                                     |
| <input type="checkbox"/> Concerned with neatness, cleanliness, or predictability                    | <input type="checkbox"/> Has trouble following directions                              |
| <input type="checkbox"/> Lacks interest in things he/she used to enjoy                              | <input type="checkbox"/> "Bullies" other children                                      |
| <input type="checkbox"/> Has trouble concentrating or thinking                                      | <input type="checkbox"/> Frequently seems disorganized                                 |
| <input type="checkbox"/> Puts him/herself down a lot  | <input type="checkbox"/> Fears horrible things will happen to self                     |
| <input type="checkbox"/> Has eating problems  | <input type="checkbox"/> Does not seem to care about other's feelings                  |
| <input type="checkbox"/> Emotional reactions are inappropriate to the situation                     | <input type="checkbox"/> Has been in trouble with the law                              |
| <input type="checkbox"/> Afraid to be away from parent(s)   | <input type="checkbox"/> Frequently lies or steals                                     |
| <input type="checkbox"/> Has physical complaints (e.g. frequent head/stomach aches, lack of energy) | <input type="checkbox"/> Sets fires or breaks into houses or parents                   |
| <input type="checkbox"/> Runs away from home frequently   | <input type="checkbox"/> Refuses to sleep in own bed                                   |
| <input type="checkbox"/> Has temper tantrums  | <input type="checkbox"/> Uses drugs or alcohol   |
| <input type="checkbox"/> Reports seeing/hearing things that others cannot                           | <input type="checkbox"/> Is sexually promiscuous                                       |
| <input type="checkbox"/> Often hurts him/herself (e.g. head banging)                                | <input type="checkbox"/> Shows little emotions   |
| <input type="checkbox"/> Has coordination problems  | <input type="checkbox"/> Seems self-conscious about his/her body                       |
| <input type="checkbox"/> Has a problem with bowel control   | <input type="checkbox"/> Acts more like an adult than a child                          |
| <input type="checkbox"/> Frequently wets his/her pants  | <input type="checkbox"/> Has very unusual thoughts                                     |
| <input type="checkbox"/> Complains of irritation or pain in the genital area                        | <input type="checkbox"/> Refuses to talk even though can speak and understand language |
|   | <input type="checkbox"/> Other (Please explain) _____                                  |

**Medical History**

1. What, if any, complications were there during the pregnancy?
2. Were drugs or alcohol used during pregnancy?
3. What, if any, complications were there during the delivery?
4. Has your child ever had to be hospitalized (for medical or mental health reasons)?  
If yes, list the approximate date, age, reason, and length of time in hospital.
5. Please note below all medications and dosage your child has been on in the past month. Place an asterisk beside those medications you child is currently on. (\*)

6. Please indicate approximately how long it has been since your child has had a medical check-up and his/her current primary physician.

**Developmental Information**

1. Does your child have any developmental delays or problems compared to other children his/her age?

**School and Home-Related Behaviors**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

1. What, if any, problems does your child have at school (behavioral problems or learning problems)?
2. Is your child currently in special education classes? yes no  
If yes, for what subjects?

**Religious Information**

1. What are the family's beliefs about God and religion?

**Family Information**

Home Address: \_\_\_\_\_

Please complete the following for those currently living in the household.

Name	Sex	DOB	Level of Education	Employer/Occupation	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

1. What are the current sleeping arrangements that exist for your child?
2. Has your child or any of the family members had previous treatment or assessment for psychological/drug/alcohol related problems? If so, when and where?

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3. What trauma or significant losses (e.g. sexual or physical abuse, deaths, move to new town or school, loss of parent) has your child experienced in the past? Please indicate the approximate dates they occurred, as well.

How would you like for counseling to help your child?

- 1.
- 2.
- 3.

**In Case of Emergency**

Name of Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

***The above information is true to the best of my knowledge.***

Parent/Legal Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Child Therapy Policies and Procedures**

**PLEASE READ CAREFULLY**

Currently, I, Diana Bigham, am a Licensed Marriage and Family Therapist in the state of Texas. My approach to therapy emphasizes the importance of relationships, especially family relationships, in the process of change. Family members are encouraged to participate. On occasion, family members may experience some uneasiness or discomfort. Please understand that this may be necessary as a part of making positive changes. Also, the purpose of therapy is not to enhance a court case and will not be used as means of an investigation or any other legal purpose, but rather the focus is in the best interest of the client's psychological well-being. I work with children in individual therapy sessions as well.

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Under HIPAA and the AAMFT Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

**CONFIDENTIALITY**

The content of our sessions is confidential. In accordance with ethical codes of mental health professionals, confidentiality does not include information about child abuse/neglect, elder abuse, abuse of the disabled, sexual exploitation by a mental health professional, behavior or threats to harm oneself or others or if I am otherwise required by law to disclose information. In addition, a court of law may, under certain circumstances, require a therapist to testify or provide records. Minor client records are disposed of five years after the child's 18<sup>th</sup> birthday. In situations where more than one client is being seen in a family, we will discuss the limitations of confidentiality with all clients involved.

Due to recent changes in the law in Texas, I am NO LONGER bound by a duty to warn persons (other than the above mentioned situations) if you disclose they may be in danger of harm by you or someone else. Please note that by signing this informed consent, you ARE authorizing me to release any confidential information I have regarding possible danger to another person in order to keep that person(s) safe from harm. I feel this duty is morally and ethically necessary for me as a therapist and victim advocate whether the law states it or not.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a verbal or written

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treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future. This summary will likely occur in a termination/summary session as a family.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. I would also request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child while he or she is in therapy.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, fees will be charged for my participation per hour, minimum of 4 hours, for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. The fees are outlined in the Fee Policy and Procedures.

### **COUNSELING RELATIONSHIP**

Therapy sessions are typically 45-50 minutes in length. Although sessions may include revealing intimate information about your relationship(s), ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me except in case of emergency when you may contact me by phone. Please do not invite me to social gatherings, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns.

I understand that sometimes Diana will engage in brief conversations over secure messaging. These are quick and efficient means of communication. Should there be a need for immediate contact, please contact your doctor or take your child to the nearest hospital.

### **EFFECTS OF COUNSELING**

While the benefits of counseling are expected, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

### **RECORDING OF SESSIONS**

Since privacy and confidentiality establish a trusting relationship, at no point will a client or any participant in session be permitted to record the session. This includes but is not limited to audio/video recording. In the event of an exception for the therapist's training purposes, then permission to record sessions must be made in advance and in writing with consent of all parties, including the therapist.



**ONLINE/VIDEO COUNSELING**

Online video counseling is available on a case-by-case basis. An initial session in office is strongly suggested prior to online sessions because in-person counseling offers better results. Video or audio recording of online sessions is not permitted.

**HANDGUNS AND WEAPONS**

The therapy process is intended to be safe and a place for healing. To honor this process, you agree that you will not bring a handgun or weapon to the office, whether it is concealed or openly carried. You agree to waive your right to carry a handgun, even if you carry a concealed handgun license.

**CLIENTS RIGHTS AND RESPONSIBILITY**

Some clients need only a few therapy sessions to achieve their goals; others may require months or even years of therapy. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a summary session. You also have the right to refuse or discuss modification of any of my therapy techniques or suggestions that you believe are harmful. You agree to come to therapy free from the influence of drugs including alcohol. I assure you that my services will be rendered in a professional manner consistent with accepted legal and 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 can report your complaints to:

**Texas State Board of Examiners in Marriage and Family Therapy**  
**1100 West 49th Street**  
**Austin, TX**  
**(512) 834-6657**

**REFERRALS**

Should you and/or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Often the person(s) who referred you to counseling would like to know that you came. May I inform them that you have attended? Additional written consent will be requested from you BEFORE any information is given other than your regular attendance. (Please initial one.) \_\_\_\_\_ NO \_\_\_\_\_ YES

If yes, please provide all necessary contact information: \_\_\_\_\_

**CONSENT FOR THERAPY**

By signing below, you indicate you've read and understand the child therapy contract, you agree to them, and give consent for therapy. Please discuss questions with your therapist BEFORE you sign.

\_\_\_\_\_  
Child Client Signature (if age over 7)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Printed Name

\_\_\_\_\_  
Therapist Signature

As legal guardian or managing conservator of this minor child, I do hereby authorize Diana Bigham, MA, LMFT to provide therapeutic services for my child.

Parent and/or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

**Fee Policy and Procedures**

**FEES**

1. **1<sup>st</sup> session = \$175.00**
2. **2<sup>nd</sup> and subsequent sessions = \$125/hour.** \*for sessions 50 minutes in length
3. **Telephone Contact = \$25 for 6-15 minutes, \$50 for 16-30 minutes**
4. **Email = \$25 per email exchange**
5. **Form or Letter Preparation = 1<sup>st</sup> Page \$100, \$50 for each additional page.**
6. **Court Appearances and/or Documents and Forms = \$200.00 per hour\***  
\*Whether you request it, or your attorney, or if I am subpoenaed, you will be responsible for all my time regardless if I am called to the stand; including driving to court, waiting to testify, giving testimony, and preparation and research time that is required. There is a 4 hour minimum charge. In addition to my time spent, travel reimbursement will be 58.5 cents per mile. The sliding scale fee does not apply to court-related appearances or documents. Payment is required in advance. Insurance does not cover this.
7. **Payment Method-** Payment is required at the time services are rendered. You may pay in cash, credit/debit card, or check (make all checks payable to Diana Bigham). Returned checks will result in a \$30 fee.
8. **Sliding Scale-** A sliding scale is available based upon financial need. You are responsible for \$\_\_\_\_\_ each session, or \$\_\_\_\_\_ for \_\_\_\_\_ sessions.
9. **Missed Appointments & Late Cancellations-** Any appointment that is missed without 24 hours notice will result in your being billed directly for the session for a fee of \$25 for each missed appointment and late cancellation. Insurance will not cover this and it will be the client's responsibility to pay it. This fee must be paid before any future appointments may be scheduled. Additionally, until this fee is paid, all standing appointments previously scheduled will be canceled and client privileges to schedule appointments online will be denied. Clients who choose not to return to counseling will still be billed this \$25.00 fee. Repeated "no shows" or "late cancellations" may result in the therapist choosing to terminate therapy with the client. Remember that you have multiple communication options for cancelling your appointment, including calling, emailing, and leaving a voice message at any time of day.

***PLEASE NOTIFY US IMMEDIATELY IF YOU ARE UNABLE TO KEEP AN APPOINTMENT!***

**I have read and understand this section \_\_\_\_\_ (initials)**

**Responsibility**

1. You, the client, (parents in the case of minors) are responsible for payment of services.
2. We reserve the right to employ a collection agency and furnish them with your information to collect payment in the event that you fail to pay an outstanding balance.
3. When a third party fails to make timely payments, payments will be expected from the client and/or the referring parent in the case of a minor. Having health insurance benefits does not guarantee coverage for all, or any, services.
4. Third party payers include: divorced parents, divorced or separated spouses, insurance companies.

**I have read and understand this section \_\_\_\_\_ (initials)**

**Insurance**

1. We will file claims directly to your insurance company **if** you provide us with all information requested. We will accept your deductibles/copays at the time of service.
2. We will verify benefits and review with you what you will be required to pay for each session.
3. If we cannot verify benefits, you will be required to pay full fee until we receive payment from the insurance company. **You are responsible for the balance of your account regardless of the insurance status.**

**I have read and understand this section \_\_\_\_\_ (initials)**

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**620 Stoneglenn Drive, Suite B Keller TX 76248 Ph. 817-562-8800**

**Signature**

You are encouraged to ask any questions you may have at any time including before you sign this form. Your signature below indicates that you understand and will comply with the above policy and procedures. Please sign if you are 18 years and older, Parents sign for your minor child.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

I am paying today by:  Cash  Check  Credit Card

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**CLIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_  
Print Name of Client (Parent/Guardian if Client is a Minor)

hereby give my consent for Diana Bigham, MA, LMFT to use and disclose protected health information (PHI) about me to carry out treatment, and healthcare operations (TPO). By signing this form I agree to let you use and disclose my information to carry out my treatment and/or consult with other providers about my treatment.

The Notice of Privacy Practices explains in more detail how you can use and disclose my information. I have the right to review the NPP prior to signing this document. Please read before you sign below.

I may request that you restrict how you use and disclose my PHI to carry out my TPO; however, Diana Bigham, MA, LMFT is not required to agree to my request, but if she does, she is bound by this agreement. I may revoke my consent (in writing) except to the extent that disclosures have already been made in reliance on my prior consent. **If I do not sign this consent form or later revoke it, I understand that Diana Bigham, MA, LMFT will not be able to provide treatment to me.**

Diana Bigham, MA, LMFT reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Privacy Officer: Diana Bigham, MA, LMFT  
620 Stoneglen Drive, Suite B  
Keller, TX 76248

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Print Name of Client or Legal Guardian

\_\_\_\_\_  
Date of NPP

Copy Given to Client  
 Copy Not Requested By Client

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received and read a copy of  
Client Name

**DIANA BIGHAM, MA, LMFT**  
Notice of Privacy Practices

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_ Copy of NPP requested  
\_\_\_ Copy of NPP not requested