Rachel J. Jones, MMFT, LMFT
620 Stoneglen Drive, Suite B, Keller, TX 76248
Ph. 817-562-8800

Appointment Reminders and Online Scheduling

You may schedule appointments online at your own convenience, but you must first establish an account with Rachel J. Jones, 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. If you do not wish to use the online scheduling feature, you may continue to schedule appointments in person or by phone.

To schedule an appointment online, go to www.redefinetoday.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 own appointments. 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.

_______________________________________ _____________________
(Signature) (Date)

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CLIENT INFORMATION

Credit Card Authorization Agreement

I, ______________________________________, *authorize* Rachel Jones, 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)

I, _____________________________, *decline* Rachel Jones, LMFT to charge my credit card.
(Cardholder's Printed Name)

____________________________________ ________________
(Signature of Cardholder) (Date)

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CLIENT INFORMATION

Client's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss. ❑ Ms

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name):

Street address:

Home Phone: ___________________________

Is it okay to reach you there? ❑ Yes ❑ No
Is it okay to leave a message there? ❑ Yes ❑ No

Present Marital Status:
❑ Single ❑ Engaged ❑ Married
❑ Separated ❑ Divorced ❑ Widowed

City, State and Zip:

Occupation:

Employer:

Employer Phone Number:

Is it okay to reach you there? ❑ Yes ❑ No
Is it okay to leave a message there? ❑ Yes ❑ No

Name of primary physician:
____

Address and Phone:
____
____

Date of last physical: ______________________________

Referred to Diana Bigham by (please check one box):

❑ Dr. ❑ Agency ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages
❑ Other ________________________________

Other family members seen here:

DEMOGRAPHICAL INFORMATION

Ethnicity
❑ Anglo (Caucasian) ❑ Hispanic
❑ Black ❑ Multi-racial
❑ American Indian
❑ Asian/Pacific Islander
❑ Other ______________________

Birth Date:
____/____/______

Social Security Number:
____-____-______

Education Level:

❑ Less than High School/GED
❑ High School/GED ❑ Some College
❑ Degree ❑ Technical Schools

Religious Preference:
____
____

Are you open to Biblical and spiritual guidance for this issue?
____
____

Have you sought counseling before?
❑ Yes ❑ No

Other agencies or individuals from whom you have received (or are now receiving) counseling:

Name	**Address**	**Dates**

List any physical reasons in which you were hospitalized. Provide the date, injury, and location of hospital:
____
____
____
____
____

List other important information including major life adjustments, traumas, or unusual circumstances. (Include any physical or sexual abuse and when it occurred)
____
____
____
____
____

Please list all medications you are currently taking and dosage:
____
____
____
____
____
____
____

Do you have a history of drug and/or alcohol abuse? ❑ Yes ❑ No

If yes, please explain:
____
____
____
____
____
____

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Briefly describe why you are seeking help at this time:
____
____
____
____
____
____
____

How have you attempted to deal with this?
____
____
____
____

Check any of the following that are currently causing you difficultly:

❑ Health Problems ❑ Anxiety ❑ Depression
❑ Alcohol/Drug Abuse ❑ Family Problems
❑ Divorce ❑ Marriage ❑ Finances ❑ Work/Career
❑ Temper ❑ Suicidal Thoughts ❑ Thinking Problems
❑ Relationship Problems ❑ Eating Problems
❑ Other, please explain:
____
____
____
____
____
____

Check any of the following that you have ever had problems with:
❑ Eating ❑ Sleeping ❑ Disease
❑ Serious Injury ❑ Illness or Allergies
❑ Psychological Problems

Check if you ever consulted with a psychiatrist. List date.
❑ Yes, __________________ ❑ No

Check if you have been hospitalized for psychological reasons: ❑ Yes ❑ No
If yes, please explain:________________________________
____
____

FAMILY INFORMATION

Mother's Name: ______________________________
Age: ______ Occupation: _____________________
Martial Status ❑ S ❑ M ❑ Sep ❑ Div ❑ Remarried ❑ Wid
Briefly Describe Her: ___________________________
____
____
____
____

Father's Name: _______________________________
Age: ______ Occupation: ______________________
Martial Status ❑ S ❑ M ❑ Sep ❑ Div ❑ Remarried ❑ Wid
Briefly Describe Him: ___________________________
____
____
____
____

Please list all persons living in your home in order of their age, beginning with the oldest:

Name (First and Last)	Age	Sex	Relationship	Occupation

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship:	Home phone:	Work phone:

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

Client/Guardian signature ____ *Date* ____________________________

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Procedures and Policies

PLEASE READ CAREFULLY

Currently, I, Rachel J. Jones, 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.

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, 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. All files are kept confidential and will be disposed of after five years of closing the file for an adult. 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.

In the case of marriage or family therapy, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any confidential information to be detrimental to the therapeutic process.

APPOINTMENTS

Since I operate on an appointment basis, your appointment time and office space are reserved <u>exclusively for you</u> at the specified time and place. I may have traveled from another city to be available at your appointment time. <u>It is important that you notify me 24 hours in advance if it is necessary to change or cancel your appointment. Failure to do so will result in losing your scheduled time for appointments and you will be billed accordingly for $25 for each missed session or late cancellation.</u>

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.

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.

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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

Please sign below, indicating that you have read and understand these procedures and policies and that you agree to them and give your consent for therapy. If you have any questions please discuss them with your therapist BEFORE you sign. Thank you for your confidence in my services. Please sign below.

_________________________________ _________________________

Client Signature Date

_________________________________ _________________________

Client's Printed Name Rachel J. Jones, MMFT, LMFT

As legal guardian or managing conservator of this minor child, I do herby authorize Rachel J. Jones, MMFT, LMFT to provide therapeutic services for my child.

Parent and/or Guardian ________________________________ Date ________________

Witness____ Date ________________

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Fee Policy and Procedures

FEES

1. **1st session** = **$100.00**
2. **2nd and subsequent sessions** = **$100/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** = 1st 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.
7. **Payment Method-** Payment is required at the time services are rendered. You may pay in cash or check (make all checks payable to Rachel Jones). 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 $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.
4. Third party payers include: divorced parents, divorced or separated spouses, insurance companies.

I have read and understand this section ____ (initials)

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

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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 Rachel J. Jones, MMFT, 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, Rachel J. Jones, MMFT, LMFT-A 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 Rachel J. Jones, MMFT, LMFT will not be able to provide treatment to me.**

Rachel J. Jones, MMFT, 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: Rachel J. Jones, MMFT, 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

RACHEL J. JONES, LMFT
Notice of Privacy Practices

.

______________________________ ____________
Signature of Client/Parent/Guardian Date

____ Copy of NPP requested
____ Copy of NPP not requested