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. 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.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 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)

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Credit Card Authorization Agreement

CLIENT INFORMATION

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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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
Rachel J. Jones, LMFT

____
Signature of Parent/Guardian

____
Relationship to Child(ren)

____
Date

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Parent Intake Form for Minor

Child's Name: ___________________________________   Ethnicity: _______________

Present Concerns:

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

___Cries easily
___Wishes he/she was dead
___Worried/anxious no matter where he/she is
___Has sleeping problems
___Concerned with neatness, cleanliness, or predictability
___Lacks interest in things he/she used to enjoy
___Has trouble concentrating or thinking
___Puts him/herself down a lot
___Has eating problems
___Emotional reactions are inappropriate to the situation
___Afraid to be away from parent(s)
___Has physical complaints (e.g. frequent head/ stomach aches, lack of energy)
___Runs away from home frequently
___Has temper tantrums
___Reports seeing/hearing things that others cannot
___Often hurts him/herself (e.g. head banging)
___Has coordination problems
___Has a problem with bowel control
___Frequently wets his/her pants
__ Complains of irritation or pain in the genital area

___Withdrawn
___Constantly seeks approval
___Has trouble paying attention
___Has trouble sitting still
___Has trouble following directions
___"Bullies" other children
___Frequently seems disorganized
___Fears horrible things will happen to self
___Does not seem to care about other's feelings
___Has been in trouble with the law
___Frequently lies or steals
___Sets fires or breaks into houses or parents
___Refuses to sleep in own bed
___Uses drugs or alcohol
___Is sexually promiscuous
___Shows little emotions
___Seems self-conscious about his/her body
___Acts more like an adult than a child
___Has very unusual thoughts
___Refuses to talk even though can speak and understand language
___ 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?

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: _________________

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Child Therapy Policies and Procedures

PLEASE READ CAREFULLY
Currently, I, Rachel J. Jones, LMFT am a Licensed Marriage 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 18th 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

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 with me 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 Rachel will engage in brief conversations over email. Please note that these are quick and efficient means of communication, but should there be a need for immediate contact, please call or should it be a mental health emergency 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.

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 the child therapy contract 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 our services. Please sign below.

_________________________________ _________________
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 herby authorize Rachel J. Jones, MMFT, LMFT-A under the supervision of Diana Bigham, MA, LMFT-S, RPT-S 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** = **$100.00/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. 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 Rachel J. 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 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)

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 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

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

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received and read a copy of

Client Name

RACHEL J. JONES, MMFT, LMFT

Notice of Privacy Practices

.

______________________________________   __________________

Signature of Client/Parent/Guardian   Date

____ Copy of NPP requested
____ Copy of NPP not requested