MATTHEW W. TURNER, PH.D., ABPP / FAACP
Board certified in Clinical Psychology, American Board of Professional Psychology
Fellow of the American Academy of Clinical Psychology
Clinical & Forensic Psychology

4601 Spicewood Springs Rd., 4-200
Austin, Texas 78759

Office (512) 767 -5539
Fax (512) 467 - 8658

DOCTOR-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. ***When you sign this document, it will also represent an agreement between us.*** You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy.

I usually schedule a 45 minute session (one appointment hour of 45 minutes duration) per week or at specified intervals at a time we agree on.

I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. In an emergency go to the nearest emergency room or call 911.

PROFESSIONAL FEES & PAYMENT

The fee for each 45-minute session is **$150.00**. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include: report / letter writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals, preparation of records or treatment summaries for another professional, and the time spent performing any other professional services you request. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I charge $200.00 per hour for preparation and attendance at any legal proceeding. **No shows or cancellations with less than 24 hours notification will result in a $150.00 charge (or the contracted rate I have with your insurance company) to your credit card. No exceptions.**

You will be expected to pay for each session at the time of service unless other arrangements have been made. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. ***This will involve utilizing a collection agency to collect unpaid fees, collection fees charged by the collection agency and interest.*** In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services and contact information.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. Some exceptions are:

- If a patient seriously threatens to harm himself/herself or another person
- If I have cause to believe that a child under 18 (or person 65 and older) has been or may be abused or neglected
- If a court order or other legal proceedings or statute require disclose.
- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential.
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.
- If your report to me that you are a victim of sexual abuse by a mental health professional or member of the clergy.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. If I refuse your request of records, you have a right of review, which I will discuss with you upon your request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, if treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 13 and 17, because privacy in psychotherapy is often crucial to successful progress, it is my policy to request an agreement from the patient and his/her parents as to what information from the therapy sessions will be disclosed to parents. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT (please read carefully)

Most major insurance companies will pay a portion of the cost of psychotherapy after you have satisfied the deductible. If we have established a relationship with your insurance company, we will collect your deductible or co-pays and bill the insurance company. Otherwise, your insurance payments go directly to you. An itemized statement will be provided at your request so that you can submit claims. Payment is always required at the time of service, even when using insurance. All session times not covered by insurance will be charged at the regular fee for service rate. When anticipating a change in insurance coverage, it is important to discuss this with me **ahead of time**, as this may affect continuity of care.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that I can provide requested information to your carrier.

A copy of a valid credit card, front and back, must be provided prior to beginning service. If insurance does not reimburse for any reason: I will bill your credit card and notify you immediately. I am happy to arrange a payment plan if the amount is large (over $250.00). I will also be happy to provide any statements you may need to seek reimbursement from your insurance company. ***If you do not wish to provide a copy of a valid credit card: payment in full at the contracted rate I have with your insurance company is due at the time of***

each service and a statement will be provided to you to seek reimbursement from your insurance company.

Finally, if paying utilizing a credit card, I bill the amount plus the cost per credit card transaction. For example, a $20.00 dollar copay would be charged as $20.40 via credit card. There is no additional fee for paying with cash or check.

I have read and understand the above information and agree to these conditions.

Signature of Client/Guardian/Personal Representative	Date
Please print name of Client/Guardian/Personal Representative	Date

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CREDIT CARD AUTHORIZATION FORM

Name: _____

Date: _____

I am providing the following credit card information to Dr. Matthew W. Turner to keep on file:

Select One: VISA MASTERCARD

Signature: _____

Office Staff to Fill Out Below

Card No.:_____

Expiration date: _____

Card Security Code (3 digit code on far right on back of card):_____

Name on Card: _____

Credit Card billing address:

City: _____ State:_____ Zip Code:_____

Card Holder's phone number: _____

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INSURANCE INFORMATION

Call your insurance company and acquire the following information BEFORE meeting with Dr. Turner:

1.) Preauthorization No.:_____

2.) Deductible Amount: _____

3.) Copay Amount: _____

4.) Number of sessions allowed to have: _____

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Release of Information

I (We),_____,
authorize **DR. MATTHEW W. TURNER** to disclose, release and / or obtain information and / or records regarding_____
(your name or client's name)
to / from:

( ) **Your Family Physician_____**

Phone #:_____

( ) Family member(s) _____

Phone #:_____

( ) Party making referral _____

Phone #:_____

( ) Previous therapist _____

Phone #:_____

( ) Other _____

Phone #:_____

- This includes information relating to my medical history, social data, psychological testing, treatment, and / or progress notes. My signature below indicates that I understand and agree to the above authorization for a period of one year from the date signed. I realize that it can be revoked by me at any time, in writing.

_____ _____
Signature of client (or parent/guardian) Date

_____
Printed Name

_____ _____
Signature of client (or parent/guardian) Date

_____
Printed Name

CLIENT HISTORY

Name: _____

Psychiatric History:

What psychiatric medications, if any, do you take? _____

_____

_____

Have you ever been hospitalized for psychiatric reasons? (Include hospital name, dates, and reasons for hospitalization) _____

_____

_____

Are you currently seeing a psychiatrist, psychologist, therapist, etc.? (Include name and contact information)

_____

_____

_____

Has anyone in your family ever received psychiatric treatment or have a psychiatric illness? ____

_____

_____

Medical History:

What medications do you take regularly, including over the counter medications? _____

_____

_____

What medical problems do you have? _____

_____

Social History:

Married? If yes, how many years _____ In a long term relationship? How long? _____

Children? Name, sex and ages of all children: _____

_____

_____

Currently employed? _____ Occupation: _____ How long employed. _____