FAITH BEHAVIORAL HEALTH

Monique Kemp, (LCSW)

1400 Coit Rd Bld 22 Ste 2204,
McKinney, TX 75071
Tel. (469) 397.4234 Fax. (469) 319.8363
faithbehavioralhealth@proton.me

PATIENT INFORMATION

First Name	Middle Name	Last Name	Sex ☐ Male ☐ Female

Street Address	Birthdate	Age
	/ /	

City	State	Zip Code	Home Phone

Cell Phone	Email address	Okay to leave voice mail ☐ Yes ☐ No

IN CASE OF EMERGENCY

Emergency Contact:	Relaonship to Paent:

Emergency Contact Number:	Do we have permission to contact them regarding your appointments, billing or in case of emergency? ☐ Yes ☐ No

THE FOLLOWING INFORMATION MUST BE COMPLETED

PRIMARY INSURANCE	INSURER / RESPONSIBLE PARTY	
Name:	Name:	Date of Birth: / /
Address:	Employer:	
Phone:	Address if different than paent:	
Idenficaon #:		
Group #:	Relaonship to paent:	

Who referred you to North Dallas Center for Healthy Minds?

Current Medicaons/Dosage/Physician

Briefly state your reason for this visit

NOTE: Payment is expected at the me services are rendered. Failure to provide us the informaon requested may result in a reducon or denial of payment by your insurance

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PATIENT HEALTH QUESTIONNAIRE

Patient's Name: _____ Date: ____/____/____

Over the past 2 weeks, how often have you been bothered by any of the following problems? Please Check the Box That Applies.	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

If you checked off any problem on this questionnaire so far how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ **Not Difficult At All** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

_____
Signature

RECIPROCAL CONSENT TO EXCHANGE INFORMATION AND RECORDS

Client's Name: _____ Date of Birth: ____/____/____

I, _____, hereby consent to the release of privileged information and records and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation and authorize:

Faith Behavioral Health
1400 Coit Rd Bld 22 Ste 2204,
McKinney, TX 75071
(469) 397.4234

and

_____
Name

_____
Address

_____ _____
Phone Fax

To exchange reciprocal information and records for the purpose of clarifying and enhancing my care and treatment including but not limited to:

___☐___ Psychiatric Evaluations
___☐___ Psychological and / or Academic Testing
___☐___ Diagnosis, treatment Plan and Progress Notes
___☐___ Parent Consultations (if the client is a minor)
___☐___ Other: _____

Monique Kemp, (LCSW) is hereby released from any and all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization. (A duplicate, photo static copy or facsimile reproduction of this authorization may be used in lieu of the original.) This authorization is subject to revocation in writing only by the undersigned.

Signature: _____ Print Name: _____

Relationship to Client: _____ Date: _____

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

(INSURANCE CARRIER)

I do hereby consent and authorize Faith Behavioral Health to release all information contained in my financial and medical records, including diagnoses and test results, to my insurance company or health plan, their agents and independent contractors, or any other person or entity that is responsible for paying or processing for payment any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.

I understand that I may revoke this consent at any time by giving written notice to the Faith Behavioral Health except to the extent that action has been taken in reliance thereon. If no prior notice of revocation is received, this consent will expire six (6) months after the date of patient discharge from treatment, unless another date or condition is specified.

I understand that if I refuse to consent to this Release of Information, the consequences will be that the insurance claim will not be filed.

Signature of Patient or Parent/Guardian	Date

Notice to Receiving Agency/Person

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my or my child's insurance company to pay directly to Faith Behavioral Health any insurance benefits otherwise payable to me or my child, if any by reason of the services described in the itemized statement rendered, and subject to the terms and limitations found in my insurance policy with the aforementioned company. THIS IS A DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assigned, and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____
Signature of Insured or Insured Representative	Date
_____	_____
Signature of Patient	Date

THIS AREA LEFT BLANK INTENTIONALLY

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Please read and initial the following statements concerning our office policies:

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

_____ I understand that if I arrive more than 10 minutes late for an appointment, it is not guaranteed that I will be seen. A $75.00 no show fee will be charged for this appointment if the schedule does not allow for you to be seen.

_____ I understand that payment is required at the time services are rendered and I assume responsibility for this. I understand there is a $30.00 fee for all returned checks.
(*Note to divorced parents: Payment is the responsibility of the parent that brings the child into the office for treatment regardless of the divorce decree. The divorce decree is a matter between the divorced parents and the courts and we cannot be placed in the middle*

_____ I understand that insurance will only be filed with insurance companies that Faith Behavioral Health and Monique Kemp, (LCSW) is contracted with. In order to achieve this, please have all current insurance information on file. I understand that secondary insurance will not be filed.

_____ I understand that if there are any changes in my insurance coverage, I will notify the business office at least five (5) days prior to my next appointment or the visit will be self-pay or rescheduled.

_____ I understand that all information obtained in regards to my insurance coverage is not a guarantee of payment by my insurance company. The amount collected at the time of service is only an estimate. I understand that I am ultimately responsible for any and all balances on my account.

_____ I understand it is my responsibility to keep my appointments. If I am unable to keep my appointments, I will notify the office at least 24 hours in advance. I understand that I will be charged $75.00 for the time reserved if I do not call and cancel or reschedule at least 24 hours prior to my scheduled appointment.

_____ I understand that regular office hours are Monday – Friday, 8:00 am – 5:00 pm.

_____ I understand it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that request received outside regular business hours will not be called into the pharmacist until the next business day.

_____ I understand that my records are protected by special laws governing therapy/substance abuse records and that I must sign a “Release of Information” form before any records can be released.

OFFICE POLICIES AND PROCEDURES
PAGE 2

☐ I understand that Doctors / Therapist do not fill out FMLA, or disability, paperwork.

☐ I understand that Doctors / Therapist do not write support animal letters.

☐ I understand that Doctors / Therapist do not appear in court to defend patients/ clients, if for any reason there is a subpoena the client will be responsible to pay $1,500.00 for half a day or $3,000.00 for a full day in court. Payment will need to be collected in advance.

☐ I understand that Therapist do not do any mental evaluations for court cases.

☐ I understand that FBHG has the right to terminate any patients who are non-compliant to office polices / medications. This includes multiple no shows without advance notice (work meetings are not an excused absence), showing up late to appointments on a regular basis, and losing or throwing away medications.

Your calls are welcomed and we will return them promptly during business hours. We do not have an after-hours answering service. You must call the office and leave a voice mail. If you need to make an appointment please call during our business hours. If you have an emergency please call 911 or go to the nearest Emergency Room.

I hereby authorize Monique Kemp, (LCSW) to provide counseling services to: ☐ me ☐ my child

_____ _____

Signature of Patient or Parent (If patient is a minor) Date

FAITH BEHAVIORAL HEALTH, PLLC

PATIENT INFORMED CONSENT DOCUMENTS

1. Description of Credentials: I am a Licensed Clinical Social Worker and Licensed by the Texas State Board of Examiners. Complaints may be filed at Complaints Management and Investigation Section, P. O. Box 141369, Austin, Texas 78714-1369. I am an independent contractor/provider not integrated and associated in a partnership or other legal entity with any other providers.

2. Description of the Services I Provide: As a Licensed Clinical Social Worker, I provide but am not limited to long-term and short-term counseling and psychotherapy for individuals, couples, groups and families. My therapeutic approach is specifically tailored for each patient; however, talk therapy is the main modality for all of my patients. It is important to note that at some points in therapy uncomfortable topics/painful topics will likely come up. As such, you may not feel better when you leave therapy at certain times and certain symptoms may become more pronounced. Whatever the issue, our work is based on the assumption that therapy paves the way for clients to utilize their innate capacity to create solutions for themselves. It is my lifelong mission, a privilege and an honor to work with patients along their journey to true happiness and health.

3. Procedures for Appointments: Appointments may be scheduled to up eight weeks in advance. Appointments will ordinarily be 45-50 minutes in duration, once a week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice you agree to pay a fee of $75.00 for the missed session prior to the commencement of any future therapy sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Office appointments can be rescheduled /cancelled by calling (469) 397.4234 during normal business hours from 8:00 am to 5:00 pm central daylight/standard time. Calls for rescheduling or cancelling purposed made outside of business hours will not be accepted.

4. Length and Number of Sessions: As each patient is unique, I cannot predict how many sessions may be required to address your problems or concerns. It is my policy that the initial session is strictly evaluation only. Being seen for the first session in no way implies that I have agreed to treat you or your children/spouse/family members therapeutically.

5. Relationship Between the Therapist and Client: The therapeutic relationship is the only relationship that we can have. By keeping our relationship strictly professional this ensures the best chance of success for you. I cannot be involved in a social relationship or friendship that exists outside the therapy room. Limiting our relationship to the therapy office keeps your therapeutic environment safe, secure and free of outside complications that could interfere with your therapy work. It is my policy that if I see current or former patients in public, not to acknowledge them unless they do so first, thereby maintaining confidentiality. Additionally no relationship of any kind can exist on any social media websites; this includes such things as liking on Facebook for example. I cannot and will not accept any gifts or invitations to family gatherings/functions. I cannot spend time with you socially or attend any religious ceremonies with you. It is not appropriate for you to try to engage me in conversation in person or by phone, at my home or anywhere outside of my office. The only appropriate phone contact outside of

the office is to reschedule a future appointment. If the line is crossed by you I will have to terminate therapy and refer you to another therapist.

6. Goals, Purposes and Techniques of Therapy: Therapy will be comprised mainly of talk therapy between therapist and patient(s). Therapeutic goals will be jointly decided on and agreed to by myself and only the undersigned parties involved in treatment. The patient(s) may at any time stop receiving treatment for any reason. The patient may at any time ask for an alternative treatment method to be provided and if it is within my professional scope I will try to accommodate. The patient at any time may ask for and be given a referral to another qualified therapist or provider.

   Initial agreed upon therapeutic goals: To be completed by Therapist.

7. Fees/Payment: Fees for individual therapy sessions are $135.00 per 45 minute sessions. Fees for couple's sessions are $160.00 per 45 minute session. The initial evaluative intake session is $195.00. The initial evaluation session is a requirement in all cases. Payment is due in full prior to being seen for your scheduled therapy appointment. There is no exception to this rule. If I am summoned or subpoenaed by you, your spouse, family members, attorneys or associate to a court proceeding you agree to pay my expenses at the rate of $500.00 per hour. This includes time spent in preparation for court, time traveling to and from court and any time procuring documents and or writing notes that will be used in court proceedings of any kind. Additionally, you agree to pay a $5,000.00 retainer fee up front, prior to me making any appearances or statements on either party's behalf if you involve me in any way in a legal/court proceeding of any kind.

8. Duty to Warn: When one receives care for mental health and/or substance abuse, information related to that care might be more protected than other types of health information. Communications with a therapist in treatment are privileged and may not be disclosed without your written permission, except as required by law. The following are situations in which a mental health professional is required by law to reveal information: (a) If a patient threatens bodily harm or death to him/herself or to another person; (b) If a court of law issues a legitimate court order (signed by a judge), the practicing therapist will be required by law to provide the information specifically described in that order; (c) If a patient reveals information relative to child abuse, child neglect or elder abuse (past or present). Also, (a) If a patient presents to therapy, by order of a court of law, the results of the treatment ordered must be revealed to the court; (b) if any sexual improprieties by a former therapist are reported, the therapist must report this to the state licensing board; (c) If any sexual improprieties by clergy are reported, the therapist must report this to the District Attorney; (d) If a patient is seeking reimbursement through an insurance company, it will be necessary to reveal confidential information to them; (e) Banks and credit card companies may be made aware that a person is receiving services from me due to check and credit card processing; (f) If a patient files a complaint or malpractice suit against a therapist, I reserve the right to use my therapy records to depend myself in court. Patient's records may also be used to sue for delinquent payment. Protection of client confidentiality is of utmost importance. I uphold the highest

standards for guarding your personal information. A patients personal, written consent is required should the need arise for one's information or records to be shred for any other reason other than those required by law as stated above.

In the event that the undersigned therapist reasonable believes that I am a danger physically, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

Name(s): _____

Telephone Number(s): _____

Email Address(s): _____

9. Address/Phone Numbers for Communication with Patient(s):

   Address where mail can be sent: _____

   Phone numbers I may call if necessary: _____

   Email addresses I may use if necessary: _____

10. Risk of Psychotherapy/Counseling: Therapy has both benefits and risk. Risk may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

11. After Hours Emergencies and Contacting Me: I am often not immediately available by telephone. I do not answer my phone when I am with patients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. I accept patient calls from 8:00 am to 5:00 pm weekdays only. If, for any number of unforeseen reasons, you do not hear from me or I am unable to reach you and you feel you cannot wait for a return call or if you feel you are unable to keep yourself safe, (1) Dial 911, (2) Contact Adapt Crisis Hotline of Texas at (877) 315.0488 or contact Suicide and Crisis Center of North Texas at (214) 828.1000. Both hotlines provide 24 hour mental health crisis services. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. Text messages will not be responded to at any time of communication, emails, for anything other than initial scheduling appointments will not be returned.

12. Social Media: It is not appropriate for therapist and patients to be "friends" on any social media site. Any such requests will be ignored. Any attempts to gain access or to observe my personal or non-professional information via any social media site will be grounds for termination of therapy.

13. Therapists Death/Incapacity: I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon receipt or to deliver them to a therapist of my choice.

14. Marital, Joint or Family Therapy: All parties undersigned agree that the undersigned therapist can maintain one file for all joint therapy sessions and that either spouse or any undersigned family members can access all the information in that joint/family/marital file.

15. Audio or Video Recordings: No audio or video recording of any therapy sessions can or will occur without the express written consent of the patient and the undersigned therapist.

16. Consent to Disclose Information to Defend Reputation: All undersigned parties agree to the undersigned therapist releasing confidential information as needed to rebut defamatory and untrue statements made by the patient or to file and prosecute a legal action for libel and or slander against the undersigned therapist or against Monique Kemp, (LCSW) Faith Behavioral Health.

17. Consent to Treat: I, the undersigned (or agree for my child/children), request treatment from Monique Kemp, (LCSW) for outpatient behavioral health services and hereby authorize him to administer such treatment as deemed necessary for treatment. I also certify no guarantee or assurance has been made as to the results or outcomes that may be obtained. Risk of treatment includes potential for both emotional and relational discomfort related to issues discussed during the counseling process. I understand I am free to discontinue therapy at any time. I understand that as the undersigned client(s) of Monique Kemp, (LCSW) it is my/our sole responsibility to pay in full with cash, credit card or health savings account card for all psychotherapy or counseling services prior to each session. I understand that Monique Kemp, (LCSW) accepts some insurance, has to be one of the companies that Monique Kemp, (LCSW) accepts and your policy must provide for pre-authorization before services can be rendered.

18. Waiver of Right to Child's Records/Information: All undersigned parties agree to waive parental or legal rights to viewing child or minor's clinical notes/files in the event that the undersigned therapist believes it is in the best interest of the child or minor to withhold information from the undersigned parents or legal guardians. All undersigned parties agree that the undersigned therapist controls the patient file, all information contained within said file(s) and who examines it.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Date of Birth: _____

Print Name: _____ Date: _____

Signature: _____ Date: _____

Date of Birth: _____

Therapist Signature: _____ Date: _____

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FAITH BEHAVIORAL HEALTH, PLLC

CREDIT CARD AUTHORIZATION AGREEMENT

By signing this Agreement, I am authorizing Monique Kemp, (LCSW) Faith Behavioral Health to bill my credit card, health savings card, flexible insurance spending account card, selected insurance policies accepted and approved by therapist or debit card for all professional services rendered to me, my spouse or on behalf of my minor children or other family members. I agree not to dispute any charge which may include but are not limited to the following:

All insurance deductibles, administrative fees, co-pays or excluded services or other charges not directly reimbursed by Monique Kemp, (LCSW) from my/our health insurance plan. **Initial** _____

I agree that telephone contact with Monique Kemp, (LCSW) in excess of 15 minutes other than that associated with normal scheduling services will be billed at the rate of $50.00 per 15 minute period. **Initial** _____

I agree to pay a fee of $75.00 for an individual session or $75.00 for a couple's/family session for a missed appointment if I have not cancelled with a minimum of 24 hours' notice before the scheduled appointment date in accordance with the cancellation policy. **Initial** _____

Credit Card Type: MasterCard _____ Visa _____ Discover _____ American Express _____

Health Savings Account Card _____ Flexible Savings Account Card _____

Credit / Debit Card Number _____ Expiration Date _____

Name as Printed on Card _____

Security Code _____ Billing Address _____

City _____ State _____ Zip Code _____

Print Name _____ Date _____

Signature _____ Date _____