Welcome,

I look forward to meeting with you! In the meantime, please complete the following 4 documents. For couples, each partner will need to complete the 4 documents. Bring these completed documents with you when you attend your first session. If you do not complete these documents before your appointment, arrive 15 minutes before your appointment time, and complete the documents you printed or complete the documents available on clipboards in my private waiting area.

1. ***Client Information Form 1*** – please complete this form.
2. ***Consent to Treatment*** – You just need to review this form, sign it, print your name, and date it. If you have any questions, I will be glad to answer them when we meet.
3. ***ACKNOWLEDGEMENT: INFORMATION FOR CLIENTS DOCUMENTS***- This form just acknowledges that you received a copy or had access to the documents, ***YOUR COPY: INFORMATION FOR CLIENTS DOCUMENTS*****,** available on the website www.DrMikeRoss.com. Also, your signature acknowledges that you understand that these documents are included by reference as part of your signed Consent to Treatment.

   At the beginning of our first session, I will summarize confidentiality and exceptions.

4. **FINANCIAL AND INSURANCE POLICY (3 Pages)**
   a. Please review and sign each of the 3 pages, at the bottom where indicated.
   b. In the middle of page 3 of 3, you will need to review and initial where highlighted the "Missed Appointments" policy paragraph.
   c. In the last paragraph of page 3 of 3, please select your ***Payment Choice*** my marking the appropriate option.

Thank you for completing these forms. Once again, I look forward to meeting with you! I will be happy to answer your questions, if any.

J. Mike Ross, Ph.D.
Licensed Psychologist
512-983-1120 (Voice)
512-250-1616 (FAX)
email: DrMikeRoss@sbcglobal.net
WEB: www.DrMikeRoss.com

Client Information Form 1

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification:

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____

Preferred Name (i.e., How would like to be addressed?): _____

Marital/Partner Status: _____ Social Security #: _____

Home street address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

Contact will be discreet; however, please indicate (with a √) in the first column of check boxes your preferred contact. Also, please indicate (with a √) below your preferences regarding contact and messages:

□ Home phone: _____ ***Ok to call? □-Yes □-No ****Okay to leave message? □-Yes □-No

□ Cell Phone: _____ ***Ok to call? □-Yes □-No ****Okay to leave message? □-Yes □-No

□ Other Phone, Specify _____: _____ ***Ok to call? □-Yes □-No ****Okay to leave message? □-Yes □-No

□ e-mail: _____ ***Ok to send an email to you? □-Yes □-No *Email is NOT confidential*

Calls or e-mail will be discreet, but please indicate any other restrictions or preferences: _____

_____

B. Referral:

How did you find out about my service? Please check √ all that apply.

❑ Yellow Pages, printed

❑ I did review your WEB site, DrMikeRoss.com

❑ YellowPages.com

❑ WEB search engine (e.g., Please specify: Google, Yahoo, _____ etc)

❑ Website, DrMikeRoss.com

❑ Insurance, please specify: _____

❑ Clicked on internet advertising

❑ Other source, please specify: _____

C. Your current employer: ❑ Employment is full time ❑Employment is part-time; How many hrs/wk? _____

Employer: _____ Business if self employed: _____

Address: _____

How long with this employer or had this business? _____ Occupation: _____

D. Are you currently in school? ❑Yes ❑No

School attending: _____ Credit hours per semester? ____ Major: _____

E. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Medications: _____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑Yes ❑No

F. Emergency Information: If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Relationship: _____ Phone: _____

G. Chief Concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

Consent to Treatment

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my Protected Health Information by Dr. Mike Ross, his employees, contractors (such as for billing), and professional staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. Dr. Ross's employees, contractors, and professional staff are required to comply with the Notice of Privacy Practices policy, and have access to this information only when there is an appropriate reason to do so, such as to confer with other health care providers or to submit claims for these services.

I understand I have a right to review the Notice of Privacy Practices policy prior to signing this document. A copy of the Notice of Privacy Practices policy has been provided to me.

I understand that diagnosis or treatment of me by Dr. Mike Ross may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Ross is not required to agree to the restrictions that I may request. However, if Dr. Ross agrees to a restriction that I request, the restriction is binding on him, his employees, contractors, and professional staff.

I have the right to revoke this consent, in writing, at any time, except to the extent Dr. Ross has taken action in reliance on this consent.

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients Documents." I understand that these documents are included as part of this informed consent. I also understand that the Financial and Insurance Policy document that I have signed is part of this consent. I have had all my questions regarding treatment or these documents answered fully.

I do hereby seek and consent to take part in the treatment by Dr. Ross. I understand that developing a treatment plan with him and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or procedures provided by Dr. Ross.

I am aware that I may stop my treatment with Dr. Ross at any time. I will still be responsible to pay for the services that I have already received. Under certain conditions, I understand that I may lose other services or have to deal with other situations if I stop treatment. For example, if my treatment has been court-ordered, I may have to answer to the court.

If applicable, I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, Dr. Ross may stop my treatment.

I have read, have had my questions, if any, answered satisfactorily, understand and accept the statements, cited above.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Printed Name of Client or Personal Representative Description of Personal Representative's Authority

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). Unless, noted otherwise below, my observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

ACKNOWLEDGEMENT: INFORMATION FOR CLIENTS DOCUMENTS

I hereby acknowledge that I have received a copy or have had website access to the following documents:

- **Information for Clients –** Includes information about Dr. Ross' education, licensure, and a summary of your rights
- **Notice of Privacy Practices For Personal Health Information (PHI)**
  This may also be known as the HIPAA disclosure.
- **Counseling File Disclosures and Limitations**

I have had an opportunity to review the documents, cited above, and had my questions, if any, answered. I also understand that these documents are included by reference as part of my signed Consent for Treatment.

_____
Signature of Client or Personal Representative

_____
Printed Name of Client or Personal Representative

_____
Date

_____
If not signed by client, Description of Personal Representative's Authority

Revision: 4/7/12

J. Mike Ross, Ph.D., Licensed Psychologist; 12741 N. Research Blvd., Suite 300;
Austin, TX 78759-4388; Telephone: 512-983-1120 (Voice); FAX: 512-250-1616

FINANCIAL AND INSURANCE POLICY (Page 1 of 3)

Payment: Payment in full is due at the time of service if you are not using health insurance with benefits assigned to Dr. Ross. I accept cash, check, debit and credit cards including Visa, MasterCard, American Express, Discover, HSA and FLEX cards (cards that can be processed like a credit card).

Insurance: Insurance coverage is an agreement between you, the insurance company and the employer, where applicable. Dr. Ross is not a party to that agreement and as a result is not bound by any of the covenants, limitation, or restrictions of that policy. Insurance typically pays for "medical necessity" which means that a legitimate mental health diagnosis is required for insurance payment.

Insurance (In-Network): As a service to my clients, I have contracted with an insurance service to file claims on your behalf. If I am a Preferred Provider (i.e., in network provider) for your plan, typically you are responsible for a co-pay; some plans may require co-insurance and/or a deductible.

Insurance (Not in-network, out of network): Your insurance may still pay part of your fee once you have met your deductible (if applicable). You would pay my fee for services when services are provided. I will provide a receipt that you can submit to your insurance company for reimbursement directly to you according to the benefits provided by your insurance company plan.

Note:

1. Some plans require preauthorization. The only way to know for sure is to call your insurance company or consult your benefits documentation before you begin therapy.
2. I offer a service that is free to you for determining your insurance coverage and to get authorization for services. Unfortunately, insurance companies do not guarantee that they provide accurate information during this pre-authorization process. Consequently, I cannot guarantee that this information is correct. Everyone involved in this process is making a good faith effort to get accurate information and most of the time the information provided by the insurance company is correct. Ultimately, you are responsible for paying for services that you receive.
3. You are responsible for keeping up with your insurance benefits, any changes that may occur (changes in deductibles, coverage, co-pay, co-insurance, etc.), and to verify covered benefits.
4. If you have a deductible, you are responsible for paying it. If a deductible is required, insurance companies do not pay benefits until the deductible has been paid.
5. Ultimately, you are responsible for paying for the services you receive. If your insurance company does not pay a claim for a service you received, it is your responsibility to pay for the service, even if the insurance company previously informed you or my insurance contractor that the service would be covered. Although insurance companies strive to provide accurate information, they do not guarantee that the information provided at authorization time is always accurate; instead, insurance companies state *final payment and benefits are determined when the claim is processed.*

- **For insurance, your signature below authorizes assignment of benefits to J. Mike Ross, Ph.D.**
- **If you are not using insurance, your signature below acknowledges that you understand payment is due at the time service is provided, unless other arrangements have been made previously (before your appointment) and agreed by Dr. J. Mike Ross.**

I have read, understand, and accept the policies cited above: _____ _____
Signature of Client(s) or Personal Representative Date

_____ _____
Printed Name (for Signature) If applicable, Description of Personal Representative's Authority

Revision: 4/7/12

FINANCIAL AND INSURANCE POLICY – FEE SCHEDULE (Page 2 of 3)

$160 **(*1)**	**First Session (CPT: 90801),** at least 45 – 50 minutes, but typically 55 minutes
$140 **(*1)**	**Continuing Counseling session for couple or family (CPT: 90847),** 45-50 minutes
$120 **(*1)**	**Continuing Counseling session for individual (CPT: 90806),** 45-50 minutes

SERVICES BELOW ARE NOT COVERED BY YOUR INSURANCE UNLESS SPECIFICALLY STATED IN WRITING AND SIGNED BY DR. MIKE ROSS AND CLIENT.

$15 **(*2)**	**Convenience Fee.** This fee is for sessions Monday thru Thursday at 5:00PM and later. This fee is in addition to fees ordinarily paid for the session(s). Although, some insurance plans may have a benefit that covers this charge, insurance will only pay this fee if "medically necessary" (i.e., medical emergency such as suicidal ideation) and will NOT cover this fee if for convenience (can't or won't take off work, etc.). Since submission of this fee to your insurance implies that it is "medically necessary," this charge will NOT be submitted to your insurance for payment, unless the "medical necessity" criterion is met (e.g., active suicidal ideation).
Variable **(*2)**	**Additional time for sessions** (e.g., to extend the length of a session) are available on a prorated basis according to the type of service provided (individual $120/50 minutes, couple or family $140/50 minutes).
$80 **(*2)** Per couple	**Couples Assessment System for Improvement (CASI).** Detailed report (about 40 pages) created for use by Dr. Mike Ross in working with couple. Feedback provided in regular session.
$50 **(*2)** Per couple	**PREP/ENRICH online assessment** system for premarital couple or for relationship enrichment. This includes two copies of the Couple's report (copy for each partner) and a detailed report for Dr. Mike Ross to be used in assisting couple.
$120/hour; $30 minimum **(*2)**	**Administrative services** such as completing forms for disability, time off work, writing letters, etc. Sometimes fees may be limited by law (e.g., for social security disability benefits). No charge for receipts, account statements or statements for attending sessions.
$120/hour **(*2)**	**Telephone Consultation** greater than 10 minutes cumulatively. First 10 minutes cumulatively is no charge, afterward, charged at $2/minute. No charge for scheduling or rescheduling or for discussions related to setting the initial appointment.
$50 **(*2)**	**Charge for sending a copy of my file for you to someone else.** Records sent to another mental health professional may be sent for free (up to 20 pages free; $0.50 per page over 20 pages). $50 charge covers up to 100 pages; additional pages are $0.50 each.
$250 **(*2)** 4 hour minimum	**Extended Services**, those provided outside of office or otherwise by Dr. Ross including response to a subpoena, court, corporate consulting, deposition, etc. This rate is calculated from the time Dr. Ross leaves the office until he returns to the office in association with providing this service (i.e., includes transportation time, waiting time, deposition or court appearance time, etc). This rate also applies for related preparation at office in support of this service. Client is responsible for this fee whether service is requested by a subpoena or by mutual agreement with client. If the service is provided in support or related to a client or their file, client is responsible for payment of this fee. For these services, a minimum payment of a $1000 retainer is due in advance. Travel expenses are additional if greater than 40 miles from office.
Variable **(*2)**	**Other services** (e.g., Extensive Relationship Consultation, weekend intensive sessions, etc.) may be available upon request and by mutual agreement. An estimate of fee(s) will be given upon request before services are provided.

(*1) These rates are charged to both insurance and self-pay. If I am an in-network provider and your plan covers these services, you may pay less. These services may or may not be covered; you should verify this with your insurance company.
(*2) These services are not covered by insurance, unless specifically indicated otherwise in writing by Dr. Mike Ross. Therefore, if you request and receive any of these services, you will be responsible for full payment at the time services are provided (i.e., insurance will not pay for these services).

I have read, understand, and accept the policies cited above: _____ _____
Signature of Client(s) or Personal Representative Date

_____ _____
Printed Name (for Signature) If applicable, Description of Personal Representative's Authority

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Returned check: A returned check fee of $30 will be billed for dishonored checks.

Overdue Accounts: Accounts are considered delinquent after 30-days of nonpayment. If an account reaches $100, routine visits may be terminated unless payment of the entire amount due is made at the time of service. Delinquent accounts may be turned over to a collection agency. Your final amount due may be your account balance plus a surcharge for collection fees which could be up to 40%.

Severability Statement: In the event that any one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this agreement, but this agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

_____ **(Please place your initials on the line to the left) Missed Appointments:** I understand that sometimes you may need to cancel or reschedule an appointment and genuine emergencies may occur (e.g., you are rushed to the emergency room). Clients are expected to notify the psychologist 24 hours in advance if they must cancel, *even if it is not the client's fault.* Client is responsible to provide this notice whether or not you receive a courtesy reminder for your appointment. Thus, with 24 hours notice another client may have access to that time. I understand that sometimes you must cancel for reasons beyond your control, for example, supervisor requiring you to work. For that reason, I am willing to absorb some of the cost of your misfortune with you and will not initially charge the full fee. If you cancel a session less than 24 hours ahead of time, you will be charged a cancellation fee of $65.00. If you do NOT call or send an email before appointment a fee of $100.00 will be billed to you. Insurance companies will not reimburse for missed sessions. Repeated late cancellations (2 times) may result in full fee charge of $120. The fee is payable by the time of the next appointment, if applicable.

1. I have read and understand this information and consent to engage in psychotherapy services.
2. I understand that I am financially responsible for non-covered services, and for services received that are not paid by the insurance company (even if the insurance company pre-authorized these services; although the insurance company strives to provide accurate information, they do NOT guarantee the accuracy of the information they provide; instead they state *final payment and benefits are determined when the claim is processed).*
3. Clients are encouraged to directly address any and all questions about services to the service provider, Dr. J. Mike Ross, Licensed Psychologist.
4. I understand that J. Mike Ross, Ph.D. is a sole practitioner in independent practice and not part of a group practice.

PAYMENT CHOICE: Please check option(s) below that apply to you (typically just one option).

_____ I will pay for services myself, because I do not have insurance.
_____ I will pay for services myself, because I do not want to use my insurance: _____
_____ I will pay for services myself, but want a receipt that I can file with my insurance.
_____ I will pay in coordination of insurance benefits per this signed *Financial and Insurance Policy.*
_____ Payments for services will be as follows: _____

I have read, understand, and accept the policies cited above: _____ _____
Signature of Client(s) or Personal Representative Date

_____ _____
Printed Name (for Signature) If applicable, Description of Personal Representative's Authority

Revision: 4/7/12