10317 Greenbriar Pl., Suite 300
Oklahoma City, OK 73159
(405) 237-8665 (phone)
stevie@steviewilsonlpc.com

Welcome

Welcome! I appreciate you seeking services at my office and hope the information and policies contained here answer questions you have about the services and costs associated with your assessment and/or treatment. The following guide explains the policies concerning my qualifications, services, fees, appointment, insurance and confidentiality. ***Although this document is lengthy, it is important that you read it carefully.*** You will also need to review the Notice of Privacy Policies document located at my office. If you would like to write down questions you have, I am glad to discuss them with you. As you initial and sign this document, it will serve as an agreement between us.

Please arrive on time for your appointment, I do not have a waiting area as one room is used for play therapy and the other for adult appointments. When the "In Session" sign is not up on the front door, please come in. It is important that you fully understand the services you/your child will receive in my office. I do not provide court-related services. I do not provide court testimony, custody recommendations, and letters to attorneys, or other services for court or legal purposes. My services are limited only to enhancing the mental health of my clients. If a child presenting for therapy is not in the custody of the biological parents, please come prepared with documentation regarding legal guardianship and/or contact information of the child's caseworker. If the parents share joint custody of the child, both parents will need to sign the release in order for the child to receive services.

Statement of Professional Disclosure

It is required by law that you are provided with information regarding my professional credentials. I have earned my Masters in Human Relations at the University of Oklahoma and continued post-graduate coursework to qualify for a license as a Professional Counselor in the State of Oklahoma.

I am licensed to practice as a Licensed Professional Counselor by the Oklahoma State Department of Health. My license number is 4859. You may contact the LPC office (without giving your name) at the contact information below:

Administrator, Counselor Licensing
3815 N. Santa Fe, Suite 110
Oklahoma City, OK 73118
Phone: (405) 522-3696
Fax: (405) 522-3691

Stevie Wilson, LPC has satisfactorily supplied me with information regarding her professional credentials.

Signed: ______________________________ Date: ________________

Psychotherapy

For psychotherapy, I will typically conduct an initial assessment session that lasts an hour, followed by an additional 1 to 2 sessions of 50 minutes to develop a treatment plan and decide if I can provide the required services. This assessment typically involves taking a detailed history, including the matters that bring you to psychotherapy and may involve completing testing (such as questionnaires), especially with children and adolescents. At the end of the evaluation period, I will be able to offer you impressions of what our work may include, should you decide to continue with me for therapy. Together we can decide if I am the best fit to provide the required services. Therapy involves a large commitment of time, finances and energy. You are advised to be very careful about the therapist you select. If at any time, you decide you would work better with someone else, or if you disagree with my impressions/recommendations, I will be happy to help you set up a meeting with another mental health professional.

When psychotherapy is started, I will usually schedule one 55-minute session per week at a time on which we agree, although sessions may be longer or more frequent, depending on the particular client and needs. Further, please be aware that there are risks and benefits associated with psychotherapy. While the goal of psychotherapy is generally to find solutions to problems and reduce feelings of distress, the process of psychotherapy can also involve the experience of uncomfortable feelings such as sadness, guilt, anger or frustration. There are not guarantees of what will be experienced in therapy.

Right to Accept/Deny Services

The client has the authority to choose to accept or deny psychotherapy services from Stevie Wilson, LPC. In addition, psychotherapy can be terminated by the client at any time. If Ms. Wilson chooses to terminate services, this will be discussed with you prior to doing so and you will be given a referral is necessary.

__________ **Please initial here to indicate information about accepting/denying services was read, understood and agreed upon.**

Appointments

For your first appointment, please bring in this packet of signed paperwork along with the completed therapy enrollment form. **Services cannot begin until these forms are received.**

When an appointment is made, that time is reserved and cannot be given to any other client. It is very important that appointments be kept. If an appointment time needs to be rescheduled or cancelled, please call the office so that the time may be made available to others. *Any missed appointment or late cancellation (not cancelling within 24 hours in advance), will be charged a full session fee* unless the late cancellation is made necessary by a genuine emergency. Appointments may be cancelled via text, email, or voicemail. The client is solely responsible for fees associated with missed appointments and payment will be required at the following appointment.

If two or more standing appointments are cancelled or missed, I will no longer be able to hold the weekly appointment time.

Phone Sessions

A phone session occurs when the therapist and client (or family member) carry on a conversation of therapeutic, problem-solving or information-exchanging nature. This includes when a client or guardian of a child agrees for me to conduct a professional consultation with other individuals pertaining to the client's treatment (i.e., teacher, physician, etc.). Short phone calls (under 5 minutes) are not considered sessions. Longer phone calls, however, will be billed as a telephone consultation and will be charged at the rate stated on the fee schedule. The fee for a phone session will be due at the next scheduled visit. Phone sessions will be indicated as such and are the responsibility of the client or the guardian of the client.

_________ **Please initial here to indicate information about appointments was read, understood and agreed upon.**

Professional Fees

INITIAL ASSESSMENT	60 MINUTES ………………	$150.00
INDIVIDUAL THERAPY	50 MINUTES ………………	$150.00
COUPLES/FAMILY THERAPY	50 MINUTES ……….….....	$150.00
SENSORY PROFILE ASSESSMENT	60 MINUTES ………………	$155.00
TELEPHONE CONSULATIONS	PER QUARTER HOUR …..	$ 35.00
NO SHOWS OR LATE CANCELLATIONS	………………..………………	Full Fee
COURT-RELATED SERVICES	PER HOUR ………………	$350.00

* As noted previously, I do not provide court-related services, except when someone has broken this agreement with me and I am compelled by the court to become involved with court-related matters (i.e., testifying in court under subpoena, participating in a deposition, preparing for court services, consulting with my personal attorney due to being compelled to be involved in court-related matters.)

Please note that I am out-of-network with private insurance companies. You are responsible for the bill at the time services are rendered. You can still file claims with your insurance company, but this is not a guarantee.

_________ **Please initial here to indicate that the information about Professional fees was read, understood and agreed upon.**

Payments

Payments are made at each session. The office policy is you must have a valid credit card on file. You may choose to pay with cash or check at each session or for your credit card to be charged for the full balance at the end of each week, but regardless the method of payment a valid credit card must remain on file at all times. Please see additional form for the credit card authorization.

Delinquent Accounts: If your account has not been paid for more than 60 days and arrangements for payment have not been made, I have the option of using legal means to secure payment. This may

involve hiring a collection agency or small claims court. If such legal action is necessary, the patient's name/person responsible for payment, the nature of the services provided and the amount due will be released to those involved.

Missed Payments: Unless other arrangements are made prior to services, services may be discontinued for missing payments or 2 consecutive sessions. Finance charges are also applicable if no payment is made within 30 days. Late charges are computed at 18% annually for any charge over 30 days old. A $35.00 fee will be added for any returned check.

__________ **Please initial here to indicate that the information about payments was read, understood and agreed upon.**

Medical Insurance

Currently, I am out-of-network with private insurance companies.

Even though the office will not be filing claims or working directly with any insurance companies, you can often still file claims with your insurance company. A "superbill" will be provided to you to seek reimbursement directly from your health insurance company. The superbill does not guarantee that the insurance provider will pay for the services provided, as each insurance plan is different. It is your responsibility to contact your insurance company and to submit these documents.

__________ **Please initial here to indicate that the information about medical insurance was read, understood and agreed upon.**

Confidentiality and Privacy Information

Records of your service activities are confidential and will not be released without the client (or guardian's) specific written consent, except under the conditions listed below. I may use or disclose your Protected Health Information (i.e., information in your health care record that may identify you) for treatment, payment and health care operations purposes with your consent. You may revoke such consent in writing at any time. You may not revoke an authorization to the extent that (1) we have taken action in reliance on the authorization (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy. Your psychological records will be kept a minimum of 7 years after your final session. The confidential records will be disposed of in a manner appropriate to maintain confidentiality. The exceptions to confidentiality are:

1. If the therapist suspects that child abuse or neglect has occurred or that a vulnerable adult has been abused or neglected, the law requires that it be reported to the proper authorities. This includes suspected mental or emotional abuse of a child who has witnessed domestic violence.

2. If the therapist believes that you are a clear and imminent danger to yourself or another person, the therapist may notify appropriate others to prevent that occurrence (i.e., statements of suicidal or homicidal intent)

3. If it becomes necessary to contact an attorney or a collection agency, then your name, identifying information about how to reach you and amount owed will become available to these agents.

4. In legal proceedings, patient/therapist communications are privileged with the following exceptions. A judge's court order is required for such information to be released or the patient's written release for the information. Examples of when a judge might subpoena your record include, but are not limited to: (a) If your mental status is an issue for the court; (b) The judge feels that communications are necessary to the proper administration of justice.

5. If you chose to submit a superbill to your health insurance company, you are releasing medical information that is protected by law. You are waiving some of your rights to privacy and confidentiality. It may be part of your health insurance company's standard practices to keep a record of your diagnoses stated on the superbill as part of your permanent medical file.

Patient Rights (in accordance with HIPAA)

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternate Means and at Alternate Locations: You have the right to request and receive confidential communications of Protected Health Information by alternative means or alternative locations (i.e., you may not want a family member to know you are being treated in my practice and may request we send bills to a different address).

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your Protected Health Information in my mental health and billing records used to make decisions about you for as long as the information is maintained in the record. I typically request that the review be conducted in my presence so that I can answer questions that you may have. I may deny your access under certain circumstances (for example, but not limited to: if I believe it isn't in your best interest to review the record; therapy notes are generally not released; information released to me by other providers cannot be released). In some cases you may have this decision reviewed. A copying charge not to exceed $0.50 per page will apply.

Right to Amend: You have the right to request an amendment of your Personal Health Information for as long as information is your record. I may deny your request, but will discuss the reasons for such a denial.

Right to an Accounting of Disclosure: You generally have the right to receive an accounting of disclosures of your Personal Health Information. Counselor Duties under HIPPA: HIPPA requires that you read my Notice of Privacy Practices which is a separate document from this one. Copies of the notice are always located in the binder on the front reception desk so that you can review it at any time. You can also request a copy of that notice for your own records. I, and the staff in my office, are required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of our legal duties and privacy practices with respect to your record. I will abide by the terms in this policy, unless we notify you of changes. You will be provided with copies of new policies and procedures. Further, you should be aware that pursuant to HIPAA and professional ethics codes, I keep professional records containing your Protected Health Information in parts of your file.

_________ **Please initial here to indicate that the information about HIPAA rights was read, understood and agreed upon.**

Minors in Treatment

Patients under the age of 18 who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment and evaluation records. Both custodial and non-custodial parents are accorded this right to medical records under Oklahoma law. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I generally recommend that parents' consent to give up their access to their child's therapy record. If parents agree to this during therapy, I will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. With young children, I typically do have frequent collateral meetings with parents given that treatment typically involves assistance from their parents (e.g., when behavioral therapy is the primary type of therapy) and documentation of such meetings are also recorded in the child's medical record. Family meetings may be recommended when I believe that they would be helpful in a child's treatment, too. If I feel that the child, of any age, is in danger or is a danger to someone else, I will notify the parent/guardian of my concern. If I am conducting a psychological evaluation of a child, I typically send the report to the child's parent or legal guardian.

_________ **Please initial here to indicate that the information about minors in treatment was read, understood and agreed upon.**

Communications

I prefer that you text to arrange or modify appointments, as voicemail and email services may not be checked in a timely fashion. Please do not email me content related to your therapy sessions, as email/text is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails/texts I receive from you and any responses that I send to you become a part of your legal record. If you choose to email/text me, your initials below indicate your consent to be replied to by me via email/text.

Digital/Social Media Policy: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please bring them up when we meet and we can talk more about it.

_________ **Please initial here to indicate that the information about communicating and emailing was read, understood and agreed upon.**

Court Testimony and Legal Involvement

As noted previously, I do not provide court testimony, forensic assessments, custody evaluations, letters to attorneys, or any other services for court or legal purposes. My services are limited only to enhancing the health and functions of my clients. If you are seeking a psychologist who can testify on your behalf,

such as in a custody or criminal case, I will be happy to refer you to other psychologist who do provide those services. By signing this agreement and beginning either your or your child's evaluation or treatment with me, you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and-or oral testimony cannot be compelled in any case. If a subpoena is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs, and/or expenses incurred for the time required to comply with or quash the subpoena and for my time related to dealing with the subpoena. Because of the difficulty of legal involvement, I charge $350.00 per hour of time spent in preparation, travel, consultation, appearance, etc. and require that a retainer be paid in advance. These fees are your sole responsibility.

_________ **Please initial here to indicate that the information about legal involvement was read, understood and agreed upon.**

YOUR SIGNATURE ON THIS FORM INDICATES THAT YOU HAVE READ THE INFORMATION CONTAINED IN STEVIE WILSON'S OUTPATIENT SERVICES CONTRACT AND AGREE TO ABIDE BY THE TERMS WITHIN DURING OUR PROFESSIONAL RELATIONSHIP. THIS ALSO SERVICES AS AN ACKNOWLEDGEMENT THAT YOU HAVE REVIEWED THE HIPAA PRIVACY NOTICE DESCRIBED HEREIN. IF YOU ARE THE GUARDIAN OF A MINOR CHILD WHO IS THE CLIENT, YOU ARE GIVING LEGAL CONSENT FOR SERVICES FOR THAT MINOR AND ATTEST THAT YOU HAVE THE LEGAL AUTHORIZATION TO GIVE CONSENT FOR THE CLINICAL EVALUATION OR PSYCHOLOGICAL TREATMENT FOR THAT CHILD.

Client Name: ____ Client DOB: __________________________

Client Address: ____

City: _______________________________________ State: ___________ Zip Code: ______________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: _____________________

Guardian Name (if minor): ____

Signature of Adult Client/Guardian: ___________________________________ Date: ____________________

If you have any questions about your privacy rights or these policy and procedures and outpatient services contract, please direct them to Stevie Wilson, LPC at 10317 Greenbriar Pl., Suite 300, Oklahoma City, OK 73159. Thank you, and again, welcome to my practice. I am looking forward to meeting with you.

10317 Greenbriar Pl., Suite 300
Oklahoma City, OK 73159
(405)-237-8665 (phone)
stevie@steviewilsonlpc.com

Credit/Debit Card Authorization Form

Name of Cardholder: ____

Type of Card: Visa Mastercard Discover American Express Debt or Credit (Circle one)

Card Number: ______________________________ Expiration: ____________

Billing Zip Code: ____________________ CVC Code: ____________________

I authorize Stevie Wilson, P.C. to charge my card for any balance owed plus a 3% transaction fee. If my card is declined for any reason, I am responsible for the balance by cash or check.

Client Signature: _____________________________ Date: ________________