Hello,
Thank you for scheduling your first appointment. Please follow the instructions completely and remember to bring all forms with you.
I look forward to greeting you.
Thank You,
Dr. Phillips

INSTRUCTIONS FOR NEW CLIENTS:

1. Please download the forms.
2. Print on ONE side.
3. DO NOT attempt to change the format or font.
4. Fill out completely.
5. Leave “Witness” blank.
6. Confirm insurance coverage for Dr. Phillips’ services.
7. Confirm the co-pay.
8. Copy both sides of your insurance card and bring the copy with you.
9. Come prepared to pay the co-pay or full fee if you are private pay.
10. The private pay fee is $125.00 for each session.

Randall W. Phillips, PhD, LMFT
Family Therapy Practice

CONFIDENTIAL DATA SHEET

Name:		Date of Birth:		Place of Birth:	Age:
Address:					
Telephone:		Email Address:			
Marital Status:	Religion:	Race:	Gender:	Education Completed: Where:	
Place of Employment:				Length of Employment:	
Type of Employment:	Full Time	Parttime	Consultant	Other	
Previous Place of Employment:				Length of Employment:	

Name(s) of Child/Children:	Date of Birth:	Age:

Have you (or spouse) ever been involved in therapy or any other type of counseling programs? Yes____ No____

If yes, When? _____ Where? _____

Reasons: _____

Reasons for considering counseling this time: _____

Have you been referred to this agency? _____Yes _____No

If yes, by whom? _____

Reasons for the referral: _____

Are you in treatment with another counselor at this time? _____Yes _____No

If yes, with whom?_____ When?_____ How Long? _____

Have you ever been hospitalized for any mental health reasons? _____Yes _____No

If yes, When?_____ Where?_____ By Whom? _____

Have you ever, or are you now being treated for any type of chemical dependency abuse? _____Yes_____No

If yes, when?_____ Where? _____

By whom? _____ Length of treatment? _____

CONFIDENTIAL DATA SHEET

Are you presently under a physician's care for physical problems? _____Yes _____No

Name of family physician: _____ Telephone: _____

Address of physician: _____

Are you presently on any medication? ____Yes ____No

If yes, please list medication: _____

Do you have any physical handicaps or learning disabilities? _____Yes _____No

If yes, please specify: _____

What do you expect from therapy? _____

Please list everyone in your family with whom you presently live:

_____ _____

_____ _____

_____ _____

_____ _____

Identify the primary family problem(s) you are now experiencing: _____

If need be, would other relative(s) be willing to come into therapy sessions? _____Yes _____No

If no, please indicate reason: _____

Person to contact in case of emergency: _____ Telephone: _____

_____ _____

Signature Date

Randall W. Phillips, PhD, LMFT
Family Therapy Practice

INFORMED CONSENT STATEMENT FOR PSYCHOTHERAPY COUNSELING

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you, too.

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST
I.CONFIDENTIALITY
With the exception of certain specific exceptions describes below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

If you elect to communicate with me by email at some point in our work together, I am willing to respond briefly by return email, but please be aware that email and other electronic media are not completely confidential.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe you are in imminent danger of harming yourself, I may legally break confidentiality and call the police of the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you are unwilling to take steps to guarantee your safety, I would call the crisis team.
4. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

II. RECORD KEEPING
I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client's perspective, interventions and impressions from the therapist and next steps.

III. DIAGNOSIS
If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you.

IV. OTHER RIGHTS
You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time, although I recommend finding a way to give me advance notice so that I can help you end treatment well and consolidate gains (please see section below on Ending Therapy).

Because I have a limited practice, I do not have 24 hour emergency or "on call" coverage. If you believe you will need a therapist with 24 hour coverage I will be happy to make a referral. <u>If you experience a psychiatric emergency, you should call 911 or go to the nearest hospital emergency room rather than waiting for me to call you back</u>. When I am out of town for an extended period of time I will give you the name of a colleague you can contact in case of an urgent need.

V. FEES
Individual therapy or couples therapy is 45-50 minute session. You will be asked to pay for each session at the time of the session. Payment can be by check, cash, debit, PayPal or credit card. On request, a statement of the month's sessions will be furnished to you on the first of the month for the previous month's sessions and payments. You can use the statement for tax purposes or for reimbursement.

VI. ENDING THERAPY WELL
I want to make your therapy as successful as possible. For that reason, it works best to find a rhythm and structure to the beginning stages with sessions that meet regularly. To support your leaving, I request several weeks of notice prior to your actual leaving to allow you to have an experience of leaving well, with a sense of completion. If I initiate terminating you from our therapy, it will be because I feel that I am not able to be helpful to you any longer. My ethics and license requires that I offer quality service and have my clients' need as paramount in my treatment planning. If I no longer feel that I am the best or right practitioner for you, I will offer referrals to other sources of care, but cannot guarantee that they will accept you for therapy or how they will approach your treatment.

MY APPROACH TO THERAPY
I may suggest that you get involved in additional or adjunctive forms of support, such as additional counseling or a support group as part of your work with me. If another health care person is working with you, I may request a release of information from you so that I can communicate freely with that person about your care.

I may be away from the office several times in the year for vacations or to attend professional meetings. If I am not taking and responding to phone messages during those time I will have someone cover my practice. I will tell you well in advance of any anticipated lengthy absences.

YOUR RESPONSIBILITY AS A THERAPY CLIENT

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 45-50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than forty-eight (48) hours notice, within business hours (Monday-Friday), you will be charged for that session, unless I can reschedule with you within the same calendar week.

COMPLAINTS

If you're unhappy with what's happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. Please see sections on this page regarding ending therapy.

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I understand the fee per session and my rights and responsibilities as a client, and my therapist's responsibilities to me. I know I can end therapy at any time I wish.

Signed: _____

Dated: _____

Randall W. Phillips, PhD, LMFT
Family Therapy Practice

PROBLEM CHECKLIST

Please check any sign or symptom that you experience presently or have experienced in the past:

Presently	In the Past	
		Physical Concerns
☐	☐	Headaches
☐	☐	Sleep Problems
☐	☐	Weight gain or loss, appetite loss or change
☐	☐	Seizures, convulsions, tremors
☐	☐	Alcohol or drug abuse
☐	☐	Vomiting, upset stomach
☐	☐	Blackouts, fainting spells
		Relationship Problems
☐	☐	With mate/spouse
☐	☐	With parents
☐	☐	With friends or roommates
☐	☐	With children
☐	☐	With child abuse
☐	☐	With sexual abuse
		Performance Problems
☐	☐	On the job
☐	☐	Academic difficulties
☐	☐	Other _____
		Other Signs and Symptoms
☐	☐	Physically violent or assaultive behavior (your own)
☐	☐	Homicidal thoughts
☐	☐	Suicidal attempts or gestures
☐	☐	Anxiety, fears, phobias
☐	☐	Feeling of inferiority
☐	☐	Social withdrawal isolation
☐	☐	Feeling suspicious, persecuted
☐	☐	Delusions, or hallucinations
☐	☐	Anger, belligerence, temper outbursts
☐	☐	Agitation, hyperactivity
☐	☐	Sexual concerns
☐	☐	Lack of energy, motivation
☐	☐	Loss of interest or pleasure in normal activities
☐	☐	Flashbacks
☐	☐	Nightmares, night terrors
☐	☐	Crying spells
☐	☐	Difficulty concentrating
☐	☐	Stress, lack of leisure time, working too hard
☐	☐	Procrastination, poor time management
☐	☐	Self-mutilation (cutting, hitting self, etc.)
☐	☐	Impulsivity
☐	☐	Other _____

I understand that the information obtained in counseling will only be available to my counselor unless State or Federal law or professional ethics dictate waiver of this confidentiality.

Signature _____ Date _____

Limits of Confidentiality

The contents of a counseling, intake or assessment session are considered to be confidential. Both verbal information and written records about a client can not be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exception are as follows:

Duty to Warn Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of deceased client have the right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Other Provisions

When fees for services are no paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of the other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples' sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedures when making phone calls: First, we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY PHONE. Include phone numbers and how you would like us to identify ourselves when phoning you.

____HOME _____ _____ ____Yes ____No
Phone Number How should we identify ourselves? May we say the clinic name?

____WORK _____ _____ ____Yes ____No
Phone Number How should we identify ourselves? May we say the clinic name?

____OTHER _____ _____ ____Yes ____No
Phone Number How should we identify ourselves? May we say the clinic name?

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____ _____
Client's Name (Please print) *Client's or Guardian's Signature* *Date*

Randall W. Phillips, PhD, LMFT
26 Chandlers Cove
Jackson, Tennessee 38305
Email: rwphillipsconsulting@gmail.com

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

I, _____ understand that I am responsible for all fees for psychotherapeutic services provided by Randall W. Phillips, PhD, LMFT. I understand and agree that payment of the fee or co-pay is due each session. (Acceptable forms of payment include check, cash, debit, and major credit cards including American Express, Master Card, PayPal and Visa).

_____ _____

Signature of Client or Responsible Party Date

Randall W. Phillips, PhD, LMFT
26 Chandlers Cove
Jackson, Tennessee 38305
Email: rwphillipsconsulting@gmail.com

CREDIT CARD AUTHORIZATION FORM FOR ROUTINE OUTPATIENT SERVICES

(PRINT ALL INFORMATION LEGIBLE & COMPLETE FORM IN ITS ENTIRETY)

PATIENT NAME_____ DATE OF SERVICE: _____

CARD HOLDERS NAME: _____

CARD HOLDER RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT) _____

CARD HOLDER ADDRESS: _____

(FOR MAILING RECEIPT): _____

CREDIT CARD TYPE: AMEX DISC MC VISA

CARD NUMBER: _____

EXPIRATION DATE: _____/_____ CVV (ON BACK OF CARD): _____

I authorize R.W. Phillips Consulting, LLC to store my credit card information in their secure system to be used for this visit and future visits for the convenience of payment processing for myself and R.W. Phillips Consulting, LLC. I understand that not only does this storage option allow for convenient payments upon my arrival for appointments, it also allows for immediate refund processing to my account in the event of an over-payment. I understand that I have the right to decline this option or to change my payment information at any time.

CARD HOLDER SIGNATURE: _____ DATE_____

WITNESS_____

Randall W. Phillips, PhD, LMFT
26 Chandlers Cove
Jackson, Tennessee 38305
Email: rwphillipsconsulting@gmail.com

Late Cancellation/No Show Policy

Please Read Carefully

Please read and sign this document if you understand and agree with the terms.

It is understandable that there will be occasions when you need to cancel a professional services appointment. A 24-hour notice is imperative in to maintain a stable practice. Without 24-hour notice, your therapist is typically unable to offer that appointment time to another client. It is illegal to bill your insurance for a missed appointment regardless of the reason.

The full cost of your session includes any deductible, co-pay or coinsurance you would be responsible to pay had you attended the session plus the amount your insurance would have paid for your missed session (or the entire self-pay fee if you are not using insurance). Reasons for late cancellation or show will not be considered as our staff is not in a position to determine valid or invalid explanations for late cancellations/no shows. The late cancellation or no show fee is $50.00.

If you have permitted your credit card to be securely stored on file with our office, then we will simply bill your card for the late cancellation/no show at the time of the occurrence and all of your future appointments will remain in place as scheduled. However, if you have not permitted your card to be stored, then you are expected to call and pay the fee over the phone or in person within 48 hours or all future appointment will be cancelled by your therapist and no additional appointments may be scheduled until the Business Office notifies your therapist that you have cleared your balance.

Signing this form indicates that you fully agree to and understand these terms.

I fully agree with the late cancellation/no show policy: _____

Client Signature

_____

Witness

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.
The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to me in any form, whether on paper, orally or electronically to be kept confidential. This federal law gives you, the patient, new rights to understand and control how your personal health information is used. As required by law, I have prepared this explanation of how I am required to maintain the privacy of your personal health information and how I may use and disclose that information.

Record Keeping Practices
Standard practice requires me to keep a record of your treatment. This includes a general description of your emotional and psychological functioning, a diagnosis for insurance billing purposes, goals and approach to treatment, symptoms, medications, your progress and homework assignments if given. This record of treatment is your protected health information or "PHI". I may use or disclose your PHI for treatment, payment, and health care operation purposes.

I keep all records in locked files for a minimum of seven years, and for children for seven years after they turn 18. After that, at some point I will shred the documents to protect your privacy.

Until then, they will be available for your review upon written notice.

Uses & Disclosures of Your Protected Health Information
Without specific written authorization, I am permitted to disclose your health care information for the purpose of treatment, payment for services and health care operations. For example:

- *Treatment*: I may use or disclose your PHI to coordinate or manage your treatment. For example, I may need to share information with other health care providers involved in your care.

- *Payment*: I may disclose your health care information in the process of obtaining reimbursement for services, billing or collections activities, and utilization review.

- *Health Care Operations*: I may disclose your PHI during activities that relate to the business aspects of running my practice. Examples of this are quality assessment activities, accounting, case management, legal, audits, insurance and administrative services.

Other Uses & Disclosures that Do Not Require Your Authorization

- To report suspected child or elder abuse or neglect
- To report when you are a threat to yourself or another's health or safety
- To report when you are a victim or potential victim of a crime
- To report where you have committed a crime on my premises or against me.
- For law enforcement purposes such as when I receive a subpoena, court order, or other legal process.
- For health and safety oversight activities, such as the Department of Health.

- For disaster relief purposes.
- To Military authorities of US. and Foreign Military Personnel, or other governmental agency particularly as relates to national or public security.
- As required by law.
- To persons involved in your care such as a family member, your personal representative or health care worker in cases of emergency, health risks, or death. I may also contact such persons to obtain payment for your healthcare.
- To coroners, medical examiners, or funeral directors as authorized by law.
- To provide you with appointment or scheduling reminders (such as on voicemail).

Uses and Disclosures of Health Care Information with Your Written Authorization

I will make all other uses and disclosures of your PHI only when your appropriate signed authorization is obtained. You may revoke this authorization in writing at any time, unless I have already acted upon a prior authorization you permitted.

Your Rights Regarding Your Protected Health Information
You have the right:

- To receive, read and ask questions about this notice.
- Ask me to restrict certain uses and disclosures. While I am not required to grant the request, 1 will certainly honor any request granted.
- Request and receive a paper copy of my most current Notice of Privacy Practices.
- To ask me to change your health information, in writing. You may write a statement of disagreement if your request is denied, which I will store in your medical record. I am allowed to prepare a rebuttal, which will also be stored in your record.
- When you request, I will give you a list of non-routine disclosures of your health information.
- To obtain a copy of your own existing protected health information. This request must be in writing and will involve a small fee.
- To ask that your health information be given to you by another means or location.
- To cancel prior authorizations to use or disclose health information in writing. Your revocation does not affect information already released or any prior action taken upon it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.
- To file a complaint without retaliation if you believe I have violated your privacy rights. This complaint must be submitted in writing with me and/or with the US. Secretary of Health and Human Services.

Therapist's Duties
This notice describes your rights regarding how you may gain access to and control your protected health information and how I may use and disclose it. I am required by law to abide by the terms of this Notice of Privacy Practices and I reserve the right to change the terms of this notice at any time. Any new Notice of Privacy Practices will be effective for all personal health care information that I maintain, whether or not you are still in treatment with me. My revised notice will be posted in my office and you may request a copy.
If you have any questions about this Notice of Privacy Practices, please contact our office.

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. Federal and state law allows providers to use and disclose your protected information to purposes of treatment and care operations. The therapist will not disclose my record to others unless I direct him/her to do so or unless the law authorizes or compels him/her to do so.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this therapist has the right to change his/her Notice of Privacy Practices periodically and that I may contact the therapist at any time to obtain a current copy of the Notice of Privacy Practices.

By my signature below I acknowledge my receipt of the Notice of Privacy Practices.

_____ _____

Patient signature or legally authorized person Date

_____ _____

Printed Name Relationship *(self, parent, guardian, representative)*

This Form will be retained in your record.

Office Use Only
I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:
Date: Initials: Reason:

_____

Release of Information Consent Form

I, _____, authorize _____

to: ___ (send) ___ (receive) the following ___ (to) ___ (from) the following agencies or people:

Name	Address	City	State	Zip	Phone

( ) Academic Testing Results
( ) Behavior Programs
( ) Case Notes
( ) Intelligence Testing Results
( ) Medical Reports
( ) Personality Profiles
( ) Progress Reports
( ) Psychological Reports
( ) Psychological Testing Results
( ) Service Plans
( ) Summary Reports
( ) Vocational Testing Results
( ) Entire Record
( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness _____ Date_____
(if client is unable to sign)

Signature of Person Informing _____ Date_____
Client of Rights

Mail to