TANYA BROWN-DAVIS COUNSELING SERVICES
6401 Eldorado Pkwy, Suite 106
McKinney, TX 75070
(469) 525-2498

CONSENT FOR TREATMENT

I authorize Tanya Brown-Davis to provide psychological services for myself and/or my child. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Policyholder _____ Date _____

ADDITIONAL INFORMATION FOR CHILD / ADOLESCENT

Child / Adolescent's Name _____
D.O.B. _____ Age _____ SSN _____ - ____ - _____
School _____ Teacher _____ Phone _____

Custodial Parents _____
Home _____ Work _____ Cell _____

If Divorced,* Non-Custodial Parents _____
Home _____ Work _____ Cell _____

Year Divorced _____ Age of Child at Divorce _____
** Please provide documentation from Divorce Decree stating who has legal authority to consent to psychological treatment.*
Please list all siblings:

_____ Age_____ Male / Female
_____ Age_____ Male / Female
_____ Age_____ Male / Female

Reason for seeking therapy _____

GUARDIAN'S CONSENT FOR TREATMENT

I acknowledge that I, _____, am the legal guardian of _____.
I hereby give my consent for him/her to receive counseling services with Tanya Brown-Davis. Treatment may include any of the following: Play Therapy, Individual Therapy and/or Family Therapy. I realize that at all times the nature and content of such services must remain confidential.

Signature of Parent or Guardian _____ Date _____

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PAYMENT POLICY

1. **Full payment for each session is required at the time the service is rendered.** Payment may be made by cash, check, Visa, or MasterCard. A co-payment of insurance will be accepted after insurance coverage is verified.

2. Filing of insurance is a courtesy provided by this office. If you prefer to file your own claim, a duplicate receipt will be provided. Secondary insurance is NOT filed by this office.

3. There will be a **$40 fee** for any **NSF check returned.**

4. Your session time is reserved just for you. If you are unable to keep your appointment, please notify us at least 24 hours in advance. In the absence of 24-hour notification, you will be billed for the session as follows unless we are able to fill the appointment time. *Missed appointments CANNOT be filed with insurance.*

Late Cancellation Fee (less than 24 hrs)	**$50.00**
No-Show Fee	**$50.00**

FEE SCHEDULE

Initial Consultation / Intake	$175.00
Therapy session 60 min	$150. 00
Therapy session 45 min.	$125.00
Therapy session 25-30 min.	$ 75.00
Therapy session 75 min.	$175.00
Therapy session 90 min.	$200.00
Court Appearance	$250.00 per hour
Parent Reporting Conference 45 min.	$125.00
Parent Reporting Conference 25-30 min.	$ 75.00
Review of Records / Consultation	$125.00/hr.
Copy of Records / Summary Report	$50.00

I have read, understand and agree to abide by the above policy.

Signature of Patient or Policyholder _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time, and I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name _____

Signature of Patient or Guardian _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature to acknowledge this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below.

Date _____ Initials _____ Reason _____