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. If you miss two consecutive sessions without providing 24 hour notice this may result in be referred to a new treatment provider. *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	$350.00 per hour
Completing Disability Forms	$50 per document
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 _____