



# Welcome to the Child & Family Guidance Center of Texoma

The Child & Family Guidance Center of Texoma, also known as CFGC, is dedicated to empowering children, teens, and families to strengthen and improve their lives. The first session will be one in which you and your therapist identify your needs/concerns and determine how best to help you, your child/children, and/or other family members.

The following forms will provide information about consent of treatment, payment and insurance reimbursements, scheduling sessions, confidentiality, HIPAA, authorization of release of information to and/or from any professionals who are/have been involved with your care (doctors, therapists, school counselors, teachers, probation officers, etc.), legal requests and records.

If at any time CFGC is not able to serve your needs, you will be referred to other more appropriate services. Please feel free to discuss ongoing therapy questions/concerns at any time with either your therapist or clinical director.

We want to provide you the best possible care, and we continually strive to improve services; therefore, you will be asked to complete some questionnaires during the time you are in counseling. Please discuss your responses with your therapist so that she/he can learn how counseling is helpful to you, or so that necessary changes can be made to better meet your needs. When you are ready to terminate therapy, we will ask you to complete a client satisfaction survey about your experience at Child & Family Guidance Center of Texoma. Periodically we perform research studies to measure our effectiveness, and we invite you to participate.

**PAYMENT & INSURANCE REIMBURSEMENTS** The cost of your initial session is **\$130.00**. The regular session fee is **\$100.00** for individual or family sessions and **\$75.00** for group therapy sessions. **Payment is required at time of service.** We accept payment for services from **Medicaid, CHIP**, and other insurance carriers. At this time, we do not accept **CHIP** for psychological testing services. Please check with your insurance carrier before your first appointment regarding coverage and deductible information. If you have not met your deductible, payment is your responsibility. The Center will collect payment from you until your deductible is met. It is your responsibility to show proof that the deductible has been met. In the event you are underinsured or uninsured CFGC will provide payment options of a discount or sliding scale fees.

**SLIDING SCALE FEES** are based on the **TOTAL NET** household income (including income from **ALL** persons living in the home), and based on the number of people supported by the total income(s). **To qualify you must provide proof of NEED by providing household income information (pay stubs, W-2's, income tax returns, child support, etc) at the first appointment.**

## APPOINTMENTS, CANCELLATIONS, NO-SHOWS

**Unless a verifiable emergency exists, clients are expected to cancel or re-schedule appointments 24 hours in advance.** CFGC's voice mail will record the day and time of all messages left. If appointments are cancelled on a consistent basis or appointments are missed two weeks in a row without good cause, CFGC reserves the right to refer client elsewhere for services. Counseling sessions may **NOT** be conducted by phone. However, if an emergency exists, the clients can speak **BRIEFLY** to his/her therapist by phone.

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on CFGC or its therapists to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. However, if any exceptions occur, you will be charged at the prevailing current rate for such services, and some services will require pre-payment.

## MISCELLANEOUS

1. **If either parent or child is sick, PLEASE, call CFGC to reschedule your appointment.**
2. **When Sherman schools are closed due to bad weather, CFGC is CLOSED also. This is SUBJECT TO CHANGE. If the Center can open scheduled clients will be notified.**
3. CFGC accepts **no** responsibility for children who are left unattended.
4. Children under the age of 12 years **MUST** be accompanied by a parent/guardian who must remain at Center during therapy.
5. Some therapists at CFGC are Masters or Doctoral level counselor interns who may see clients. All interns are supervised by licensed supervisors. Interns and therapists may discuss your case with their supervisor and/or other professionals at the Child & Family Guidance Center in order to provide the best services for you. For training purposes, sessions conducted by interns may be video taped and/or recorded.

804 E. Pecan Grove Rd, Sherman, TX 75090, Telephone (903) 893-7768; Fax (903) 893-4979  
e-mail: [Help@cfgcenter.org](mailto:Help@cfgcenter.org) web address: [www.cfgcenter.org](http://www.cfgcenter.org) REVISED 2/2011

# **Child & Family Guidance Center of Texoma**

## **Complaint Process**

Complaints/questions about treatment can be addressed in the following ways(s):

1. Begin by discussing the concern with your therapist. Often, open communication will clear up misunderstandings or simple problems.
2. If you are not satisfied with the outcome of your conversation, please contact the Executive Director or Clinical Director. If at any time you believe that you have been treated unethically or that your rights as a client have been violated, you have the right to contact your therapist's licensing board:

### **Texas State Licensing Boards**

#### **Licensed Professional Counselors LPC**

Texas State Board of Examiners of Professional Counselors  
Complaints Management and Investigative Section  
P.O. Box 141369  
Austin, TX 78714-1369  
1-800-942-5540  
[http://www.dshs.state.tx.us/socialwork/sw\\_complaint.shtm](http://www.dshs.state.tx.us/socialwork/sw_complaint.shtm)

#### **Licensed Clinical Social Worker LCSW**

Texas State Board of Social Worker Examiners  
Complaints Management and Investigative Section  
P.O. Box 141369  
Austin, TX 78714-1369  
1-800-942-5540  
[http://www.dshs.state.tx.us/socialwork/sw\\_complaint.shtm](http://www.dshs.state.tx.us/socialwork/sw_complaint.shtm)

#### **Psychologists**

Texas State Board of Examiners of Psychologists  
333 Guadalupe Suite 2-450  
Austin, TX 78701  
512-305-7709  
[http://www.tsbep.state.tx.us/complaint\\_form.html](http://www.tsbep.state.tx.us/complaint_form.html)

**Please Keep This Page**

**Child & Family Guidance Center of Texoma  
CURRENT CONCERNS OF CLIENT**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender  M  F

Please check all that apply.

<input type="checkbox"/> Specific Diagnosis: _____  <input type="checkbox"/> Abuse      ___emotional___physical___sexual  <input type="checkbox"/> Anger <input type="checkbox"/> Anxiety, Worry, Fear <input type="checkbox"/> Appetite Changes <input type="checkbox"/> Behavioral Problems <input type="checkbox"/> Blended Families <input type="checkbox"/> Bullying <input type="checkbox"/> Custody Issues <input type="checkbox"/> Depression/Sadness <input type="checkbox"/> Divorce <input type="checkbox"/> Drugs and/or Alcohol Use <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Family Conflict/Life Changes  _____	<input type="checkbox"/> Grief <input type="checkbox"/> Health Problems _____ <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Illegal Behavior: ___truancy___stealing___running away___fire starting Other: _____ <input type="checkbox"/> Legal Issues <input type="checkbox"/> Marriage Problems <input type="checkbox"/> Neglect <input type="checkbox"/> School Problems _____ <input type="checkbox"/> Sexuality problems <input type="checkbox"/> Sleep/Nightmares <input type="checkbox"/> Stress _____ <input type="checkbox"/> Unusual Behavior _____ <input type="checkbox"/> Unusual Experiences _____ <input type="checkbox"/> Other: Explain _____  _____
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Estimated number of hours per day client spends watching TV, DVD's, computer use, social networking, talking and/or texting on cell phone ? \_\_\_\_\_

- **Family Atmosphere Rating** (check what best describes your child's current family atmosphere)
 

<input type="checkbox"/> Strict	<input type="checkbox"/> Chaotic	<input type="checkbox"/> Few expectations	<input type="checkbox"/> Inconsistent	<input type="checkbox"/> Non-religious	<input type="checkbox"/> Stressful
<input type="checkbox"/> Lenient	<input type="checkbox"/> Structured	<input type="checkbox"/> High expectations	<input type="checkbox"/> Consistent	<input type="checkbox"/> Religious	<input type="checkbox"/> Peaceful
  
- **Suicidal Thoughts/Attempts?\_:**  No  Yes  
 When? \_\_\_\_\_
  
- **Past Counseling Received?\_**  No  Yes  
 When/Where \_\_\_\_\_ Therapist \_\_\_\_\_
  
- **Past Psychological Evaluation?**  No  Yes, please provide copy
  
- **Past Hospitalization for problem?**  No  Yes When/Where? \_\_\_\_\_
  
- **Medications:** \_\_\_\_\_

Comments: \_\_\_\_\_

**Child & Family Guidance Center of Texoma  
CLIENT AND PAYMENT INFORMATION**

**CLIENT INFORMATION**

1. Client's First Name: \_\_\_\_\_ LastName: \_\_\_\_\_ M: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_M\_\_F Ethnicity: \_\_\_\_\_

2. Client's First Name: \_\_\_\_\_ LastName: \_\_\_\_\_ M: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_M\_\_F Ethnicity: \_\_\_\_\_

3. Client's First Name: \_\_\_\_\_ LastName: \_\_\_\_\_ M: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_M\_\_F Ethnicity: \_\_\_\_\_

4. Client's First Name: \_\_\_\_\_ LastName: \_\_\_\_\_ M: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_M\_\_F Ethnicity: \_\_\_\_\_

**RESPONSIBLE PARTY/ CONTACT INFORMATION**

Parent/ Guardian/Adult Client: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St \_\_\_\_\_ Zip: \_\_\_\_\_

**If address of client is different please provide:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ St \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

OK to call or leave message?  Yes  No Referred by: \_\_\_\_\_

**DO BOTH BIOLOGICAL PARENTS HAVE THE RIGHT TO CONSENT TO TREATMENT?  YES  NO,  
ACCESS RECORDS?  YES  NO CONSULT WITH THERAPIST?  YES  NO**

**If divorced or guardian must show legal proof (divorce decree and/or custody documents)**

**PAYMENT INFORMATION**

**Please bring insurance information to 1<sup>st</sup> session**

Medicaid  CHIP/Superior  CHIP/Molina  Private Insurance  Other \_\_\_\_\_  Sliding Scale

**SLIDING SCALE FEE**

If you do not have insurance **Sliding Scale** is available to assist our clients who are unable to pay the full amount for services. The sliding scale program is based on total household net income and family size. A copy of your most recent current pay stub, income tax return, W-2, and/or 1099 of all adults living in the household as well as any child support, unemployment or disability income is required for proof of income.

**To qualify, please complete the following and bring proof of income of all adults living in the household to your 1st Session**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_ Annual Income  
\$ \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_ Annual Income  
\$ \_\_\_\_\_

Total # of People living in household? \_\_\_\_\_ Total household Income: \_\_\_\_\_ 1<sup>st</sup> Session Fee: \_\_\_\_\_ Regular Session Fee: \_\_\_\_\_

**Child & Family Guidance Center of Texoma**  
**CLIENT SERVICES AGREEMENT**

**I. CONSENT FOR TREATMENT /EVALUATION**

I understand that determination for treatment, if any, will be made by **Child & Family Guidance Center of Texoma**. Also, I understand that any such recommendations will be explained, and that I have the option to accept or reject the recommendations.

- I certify that I have the **LEGAL AUTHORITY** to authorize and consent for

(NAME OF

CLIENT(S)\_\_\_\_\_to receive treatment/evaluation at **Child & Family Guidance Center of Texoma**. If applicable, I consent to present a copy of my divorce decree and/or custody document(s), etc., certifying my legal authority to seek psychological services for the named client.

**II. PAYMENT OF SERVICES** The cost of your initial session is **\$130.00**. The regular session fee is **\$100.00** for individual or family sessions and **\$75.00** for group therapy sessions. Payment is required at time of service.

- I agree to pay for the cost of psychological services provided.
- I understand that I am responsible for contacting my insurance company to pre-certify benefits and/or to obtain authorization for services.
- I authorize payment of medical benefits to the named provider for professional services rendered, and I authorize release of any related information necessary for my treatment and for the filing of insurance.
- I understand CFGC accepts payment from **Medicaid, CHIP**, other insurance carriers and provides discounts or sliding scale fees to underinsured or uninsured clients respectfully. I understand if a discount is provided, my insurance will not be billed.
- I understand that I am ultimately responsible for any service fee(s) not covered by my insurance carrier. Co-pays, sliding scale fees, and non-covered services are payable at time of service unless other arrangements have been made.
- If I have a psychological evaluation, my testing fee will be based upon a per person/per evaluation charge, and the fee will be explained to me at the time of testing. Payment for psychological testing is due at time of service unless prior arrangements have been made.
- If I have a check returned for non-sufficient funds, I agree to pay a **\$25.00 service fee**. Before any future visits occur, I must pay **in cash or money order** the service charge **PLUS** the value of the check.
- When I end therapy with CFGC, my account must be paid in full.

**III. TREATMENT:** I understand that I must be committed to attend sessions on a **REGULAR** basis in order to receive the greatest benefit from therapy or assessment. Although I may stop therapy or assessment at any time, I agree to inform my therapist of my decision **BEFORE** my last session. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I **CANNOT** attend a session if I am under the influence of alcohol or drugs, or if I am in possession of dangerous weapons.

**IV. APPOINTMENTS, CANCELLATIONS, NO-SHOWS**

I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment **24 hours in advance**. CFGC's voice mail will record the day and time of all messages left. If I cancel appointments on a consistent basis or miss appointments two (02) weeks in a row without good cause, CFGC reserves the right to refer me elsewhere for services. Counseling sessions may **NOT** be conducted by phone. However, if I have an emergency, I can speak **BRIEFLY** to my therapist by phone; I understand that I will be charged partial session fees after the first 10 minutes. My existing fee will be used to determine charges.

I acknowledge I have read, understood, consent to, and agree to comply with the CFGC Client Service Agreement



Parent/Guardian/Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Child & Family Guidance Center of Texoma  
CONFIDENTIALITY STATEMENT**

**Clients Who Are Dependents:**

If you are requesting services for a child as the guardian, the parent, or Managing Conservator/Possessory Conservator of that child, it will be critical that the child trust the therapist. With your understanding in advance, we shall keep what your child says/does confidential.

If we think it would be helpful to share a specific detail with you, we shall first ask the child's permission to do so, or we shall encourage the child to do so. It is important to the therapy process that he/she does not think the parent and the therapist are conspiring against him/her in any way. You have the right and responsibility to question the therapy process, to understand the nature of activities with the child, and to be informed of the child's progress. We have the right to use our clinical discretion as to what is appropriate disclosure. We shall review the child's progress in therapy with you, and we want to obtain feedback from you regarding your interactions with the child and observations of the child in various settings. In this way, we shall work as a team. We shall value your consultations with us and your involvement. We shall discuss with you how you can participate effectively in the child's treatment and progress outside of therapy.

**Client Rights:**

Clients are also assured of confidentiality, which is a protected ethical right and a Texas state law, subject to legal limits. Cases may be discussed with other therapists within this agency in order to provide continuing care and/or treatment options. Should we believe it beneficial to us and to you to consult with another professional outside our agency regarding your case, we shall notify you and obtain a release of information signed by you. At times, we may seek professional supervision or consultation of the case without identification of the client in any way.

There are some exceptions to confidentiality, which are addressed below.

**Duty To Warn - Confidentiality**

**The following are exceptions to confidentiality:**

- We are required by law to report any incidence of suspected child abuse, neglect, or molestation in order to protect the child involved;
- In legal cases, we or our records may be subpoenaed by the court system;
- Whenever obligated by law or a judge to share confidential information;
- Whenever there is a legal exception to confidentiality;
- You authorize us to notify relevant other (including a possible victim) and/or law enforcement authorities, if we judge that a client has an intention to harm self or others.

**Other Exceptions to Confidentiality are as follows:**

- Managed care organizations usually require that we consult with their case managers and provide progress updates to their organization. This is how their personnel determine whether to provide you with necessary authorization for visits. If you have a managed care plan, we have no control over the data required by your organization once it leaves our office.
  - Insurance verification
  - In divorce cases in which parents share joint custody, either parent has a right to the child's record, unless otherwise stipulated in the divorce decrees.
- If you wish utmost confidentiality to be preserved, consult your attorney and suggest/advise a Motion to Quash or a Protective Order. You are responsible to protect the file.

I acknowledge I have read, understood, consent to, and agree to comply with the CFCG Confidentiality Statement.



**Parent/Guardian/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child & Family Guidance Center of Texoma**  
**CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TP0)**

Federal regulations (HIPAA) allow CFGC to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). The Notice of Privacy Practices describes these disclosures in more detail. We reserve the right to revise the Notice of Privacy Practices at any time. If we do so, the revised Notice will be available in the waiting room. You may ask for a printed copy of our Notice at any time.

CFGC creates and uses a record of your health history and related financial information that may be used for:

- Continuing care and treatment.
- A way of communicating with other health care professionals who are involved in your care.
- A means of deriving information used in billing for your care.
- A means of responding to insurers' requests for information about your care.
- Review in quality assessment projects designed to help CFGC improve its ability to provide good health care.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. You can revoke this consent at any time; however, the revocation will not apply to uses of your records between the date of this consent and the date of revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

Please list any restrictions of the named client's mental/medical record that you do not want to disclose: \_\_\_\_\_

I hereby consent to the use or disclosure of Protected Health Information of the named client(s) for treatment, payment, and health care operations.



**Parent/Guardian/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HIPAA Notice of Privacy Practices and Office Policies & General Information Agreement for Psychotherapy Services**

I acknowledge I have access to CFGC's HIPAA Notice of Privacy Practices and Office Policies & General Information Agreement for Psychotherapy Services (copies in waiting room and on website).



**Parent/Guardian/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Communication Approval**

If needed, I authorize the CFGC clinician involved in the treatment of myself and/or my child to contact me to discuss confidential information by calling: Home phone Yes No Cell phone Yes No Work phone Yes No

I authorize CFGC and its therapists to communicate with each other and me by CELLPHONE regarding treatment of myself and/or my child(ren). Yes No



**Parent/Guardian/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child & Family Guidance Center of Texoma**

**COURT SERVICES, RECORDS, & CORRESPONDENCE CLIENT SERVICE AGREEMENT**

I/We hereby understand and agree to the following requirement and charges that I/We may incur if my therapist or any other CFGC staff is involved in a court case or related matter on behalf of myself, my spouse, my children, or my family. I/We understand that these terms are applicable both while I/We are receiving services, as well as following termination. I/We understand that if I or a family member is a victim of a crime that I/We may be eligible for the following fees to be covered by the Texas Crime Victims' Compensation.

**COURT ORDERED SERVICES AND CORRESPONDENCE/RECORDS REQUESTS:**

A **signed copy of the court order must be received by CENTER BEFORE services can be scheduled.** Once the order has been reviewed by the Clinical Director, services will be scheduled per the court order if CFGC can offer services which will comply with the order.

**Fees for Court-Related Services: ALL FEES FOR COURT TESTIMONY AND/OR CORRESPONDENCE/RECORDS MUST BE PAID IN ADVANCE. COUNSELING SERVICES MUST BE PAID AT TIME OF SERVICE.**

**1. Phone Consultations with Attorneys, Mediators, Family Court Counselors, District Attorneys:**

\$100.00/hour-quarter hour (\$25.00) minimum charge.

**2. Reports and/or client summary for court, attorneys:**

\$100.00 Per Hour/PER CLIENT for Individual Therapy \$100.00 Per Hour/Per Family for Family Therapy

**3. Court deposition or court testimony:**

\$200.00 minimum charge for first required appearance, regardless of actual time spent in court. Any additional dates of appearance will require payment of \$100.00/PER HOUR. Any out-of-town charges must be reimbursed as above and will include actual out-of-pocket travel expenses, to include mileage and/or transportation costs, tolls, parking fees, meals, and lodging. **\*\*\*By law, if a county is more than 150 miles from where a therapist resides or is served, the therapist is NOT required by subpoena to appear or produce documents.**

**4. Information for parent/guardian and copies of client file:**

Minimum charge is \$50.00. Additional charge is \$100.00 per hour of time required to prepare correspondence/records, etc. An additional charge of \$0.25 per page, with a \$5.00 minimum charge will be assessed.

**5. Counseling and psychological testing: FEES ARE SPLIT EQUALLY BETWEEN THE PARTIES AND PAID AT TIME OF SERVICE**

- a. Intake session \$ 130.00, Regular Session \$100.00 Group Session per person \$75.00
- b. Psychological testing Fees set according to scope of testing requested
- c. All other services (court ordered) Fees set according to service requested

**NOTE: SLIDING SCALE FEES DO NOT APPLY TO COURT ORDERED SERVICES OF TWO (02) OPPOSING PARTIES FOR THEMSELVES OR FOR A MINOR CHILD. UNLESS OTHERWISE NOTED, FEES WILL BE CHARGED AT THE RATES INDICATED ABOVE. ALL FEES WILL BE SPLIT BETWEEN THE PARTIES AND PAYABLE AT TIME OF SERVICE.**

**OTHER Requirements: Should any exceptions to the Litigation Limitations contained in the Office Policies and General Information Agreement for Psychotherapy Services occur, the following guidelines apply:**

- 1. **Release:** For those cases referred by the court system, clients **MUST** sign release of information forms allowing CFGC therapists to **openly communicate with all parties related to The suit.** To ensure safety and professionalism of the counseling process, **NO Exceptions will be given.**
- 2. **Subpoena:** A subpoena must be issued **before** the therapist or any other agency personnel can make a court appearance, deposition appearance, or deliver any records. **Party issuing Subpoena will be financially responsible for ALL related fees.**

I acknowledge I have read, understood, consent to, and agree to comply with the CFCG Court Services, Records & Correspondence Client Service Agreement,



Parent/Guardian/Client/Signature: \_\_\_\_\_ Date: \_\_\_\_\_



