Contact Information

Name:_____

Date of Birth:_____

Address:_____ Cell Phone_____

Email address:_____

Credit Card info;

#_____
date_____
CVV#_____
Zip _____

Name of:
Employer_____

Address of:
Employer_____

Partners
Name_____

Address of
different_____

Cell Phone_____

Health Insurance Portability and Accountability Act (HIPPA)

Patient Authorizes for Use and Disclosure of Protected Health Information By Signing: I authorize Victoria Shackelford MFA, MA, LPC to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Victoria Shackelford, MFA, MA. LPC to use and/or disclose the following individually identifiable health information about me, specifically describe the information to be used or disclose, such as dates of services, type of services, level of detail to be released, origin of information, etc.

The information will be used or disclosed for the following purpose:
(If disclosure is requested by the patient/client, purpose may be listed as 'at the request of the individual')

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of this information.

This practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Victoria Shackelford, MFA, MA, and LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.
Signed by:

_____
Signature of Patient/Client or Legal Guardian, Relationship to Patient/Client

_____
Print Patients/Client name here Date

_____
Print Name of parent or legal Guardian

I have read this notice

Informed Consent for Services
Victoria Shackelford, PhD
National Certified Counselor & Licensed Professional Counselor

Services to Adults
I, _____, request Victoria Shackelford, PhD to provide counseling services to me to achieve the goals I have set with my Counselor.

Services to Children
I represent that I am authorized to grant consent for _____ to receive professional services and request that Victoria Shackelford provide services for this child. I verify that I am the legal parent, legally authorized representative (LAR), managing conservator or a person designated by the court to have the authority to consent to provide counseling/ psychological services.

Benefits/Risks for Counseling
One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to the therapy sessions. While counseling may help you achieve a greater understanding of personal goals and values, there may be some discomfort during the therapy process as you face difficult life changes. The greatest risk of counseling is that it may not, by itself, resolve your concerns. Your counselor will consistently assess your treatment for appropriate progress.

Confidentiality
Victoria Shackelford PhD, values the privacy of clients and acts accordingly. However, there are times when the clinician is obligated by law for professional ethics to report incidents of threat to self, threat to others, child abuse/neglect, elder/dependent adult abuse/neglect or client abuse by a therapist. In the event that a litigation case is filed that concerns your clinical file, your records may be subpoenaed and we may be obligated to honor these subpoenas. I acknowledge that I have read and understand the limits of confidentially described above. _____ (Initials of client or LAR).

Clients Rights
You have the right to request services offered by Victoria Shackelford PhD without regard to race, color, national origin, age, sex, disability, political beliefs, religion, income, or sexual orientation. Any questions of ethics or complaint may be address to: The Texas State Board of Examiners of Professional Counselors: 1100 West 49th Street Austin Texas 78756: 512.843.6658.

Follow-up
I agree that Victoria Shackelford may contact me after I terminate services. This contact is to ensure the best possible services to our clients through quality control. The contact may be in the form of a phone call or correspondence. _____ (Initials of client or LAR)

Payment Policy
Victoria Shackelford, PhD operates a pay by services office. Insurance is not accepted. However, insurance receipts are offered to clients who wish to file them on their own. **There is a Full Fee charge for no-shows and late canceled appointments.** A 24-hour notification is required for canceled appointments. The first session is $168.00 and thereafter each Individual session of 50 minutes in length are $158.00 a session. I do offer reduced fee options for long term counseling. Please ask for more information.

Dr. Victoria Shackelford PhD. LPC.

I have read, understand, and have been advised by my counselor or designee concerning the contents of this document. I have read the preceding information and understand my rights as a patient/client**.**

Patient/Clients Signature Signature of Witness/ Staff

_____Date_____ _____Date_____

PSYCHOTHERAPY SERVICES
VICTORIA SHACKELFORD, PHD
LICENSED PROFESSIONAL COUNSELOR
210.602.3002

FINANCIAL POLICY $ FEES FOR SERVICES

The first appointment fee is $158.00. The one-hour therapy visit runs 50 to 55 minutes long as defined by insurance providers. Follow-up appointment fees are as follows:

Psychotherapy services-Intake first session————$168.00

Psychotherapy, individual, 50 minutes----------$158.00

Child Centered Play Therapy for parents and children--------$158.00

Psychotherapy Couple————————————————- $200.00

Group Psychotherapy, 75 to 80 minutes————————$100.00

Home Visits for children and adolescents————————--$300.00

Other services outside the scope of traditional psychotherapy will be assessed the following charges, payable in advance:

Late notice and NO SHOW FEE————————————$168.00

Attendance at court, $1500 retainer————————$500.00 minimum (first hour), $160.00 each hour following plus all travel related expenses

Letters or reports for attorneys, courts or other legal entities**----------** $168.00

Records requests charges (standard Texas charges plus postage)

First 20 pages----------$40.00

Each additional page----------$10.00

PAYMENT POLICY

Payment is due at the time of service. We accept cash, check, money order, Master card, Visa, Discovery cards both debit and charge. We will assess a $25.00 fee for any checks returned by the bank due to insufficient funds. If you require special payment arrangements please speak to our office in advance.

There is a reduced appointment fee for pre-payments on line with pay pal. Contact Victoria for details. (210.602.3002)

INSURANCE COVERAGE:

Our office does not submit insurance claims at this time. However we will provide you with a Super Bill for you to file your insurance company for a reimbursement of your appointment fee. Please note that your insurance policy is a contract between you and your insurance company; we are not a part to that contract and we have no control over how and when they will refund your fee for services.

MISSED APPOINTMENTS AND LATE CANCELED

Please understand that your appointment time is reserved for you and cannot be given to someone else on short notice. Please give at lest 24 hour notice if you cannot keep an appointment. Missed appointments and cancellations without at least 24 hour notice will be

considered a no-show and will be charged directly to you. Patients who consistently fail to attend their appointment (3 missed appointments in a 3 month period will be considered a chronic no-show and you will be discharged from therapy.) Appointment reminders are a courtesy.

STATEMENTS BILLING

Statement regarding any balance on your account will be sent to you if there are charges due. Your account may be turned over to a collection agency if payments are not made in accordance with this financial policy. If this occurs, there will be an additional charge of $80.00 assessed to cover collection costs, including office costs associated with producing and sending billing records. ***Thank you for reviewing and understanding our Financial Policy. Please let us know if you have questions or concerns***.

PSYCHOTHERAPY SERVICES
VICTORIA SHACKELFORD, PhD
LICENSED PROFESSIONAL COUNSELOR
210.602.3002

FINANCIAL POLICY $ FEES FOR SERVICES

Financial Contract:

X_____Date_____

X_____Date_____
