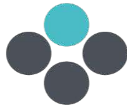

___

Legal Last Name ____________________ First Name _________________ Middle ________

Preferred Name ______________________________________ Gender _____________

Street Address _____________________________ City _________ State _____ Zip______

Mailing Address ___________________________ City __________ State _____ Zip______

Client's Social Security Number _______________ Age ______ Date of Birth __________

Mother's Name _____________________________ Phone ___________________________

Father's Name ______________________________ Phone ___________________________

List all individuals with legal custody of the child: ___________________________________

Other Phone _______________________ Email Address ___________________________

Can we contact you at Home **Yes No?** Work **Yes No**? Cell Phone **Yes No**? Email **Yes No**?

Emergency Contact Name & Phone Number _______________________________________

___

School Information

What school does the child currently attend? _______________________________________

Child's current grade level _______ Has the child ever been held back in school? [ ] Yes [ ] No

Has the child been in alternative education? [ ] Yes [ ] No Special Education? [ ] Yes [ ] No

Primary Insurance Information/ Employee Assistance Program Information

Primary Insured Name _________________________ Telephone ______________________

Street Address ____________________________ City __________ State ______ Zip _______

Name of Insurance/EAP ____________________ Insurance/ EAP Phone _________________

Insurance Member # _______________________ Plan # _______________

Primary Insured's Employer __________________ Primary Insured's Date of Birth _________

~~~~~~

Referred By/ How did you hear about Dr. Cooper?

____ Friend/Family ____ Another Therapist ____ Physician, Dr. _____________

____ Court/Legal ____ Minister ____ I am a former client returning

____ School ____ Insurance Company ____ Employee Assistance Program

____ Website/Internet ____ Yellow Pages ____ Other ___________________

~~~~~~

Laura Beth Cooper, Ph.D.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

Effective date: August 1, 2014

Laura Beth Cooper, Ph.D. has been and always will be committed to maintaining her clients' confidentiality. We will only release your health care information in accordance with federal and state laws and the code of ethics for the psychology profession.

This notice describes our policies related to the use and disclosure of your health care information.

Uses and disclosure of your health information for the purposes of: Providing treatment services, collecting payment and conducting health care operations. These are necessary activities provided for our client's quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This may include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. We may also bill the person in your family who is identified as the primary insurance holder or responsible party.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information, which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, information you and/or your child or children report about physical or sexual abuse. In this circumstance, in accordance with Texas law, we are obligated to report this to Child Protective Services. If you provide information that you are in danger of harming yourself or others. Information shared with law enforcement if a crime is committed on our premises or against one of our staff. Any other instances as required by law such as a subpoena or court order. Information to remind you of/or to reschedule appointments or other treatment alternatives.

Clinical records, psychotherapy notes, and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information.

Laura Beth Cooper, Ph.D.

CLIENT RIGHTS

Right to request how we contact you. It is our normal practice to communicate with you at your home address and via the daytime phone number you provided us when you scheduled your appointment, about health matters, billing information, and appointment reminders. If permitted by you, we may sometimes leave messages on your voicemail. You also reserve the right to request that our office communicate with you in a different way.

Right to release your medical records. You may consent in writing to release your records to others that you identify. You have the right to revoke this authorization, in writing, at any time. However, please note that a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records. You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, please contact the office manager. Under limited circumstances we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or in some cases, within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures. You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, health care operational purposes, information that was shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than seven years, please submit your request in writing to the office manager. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, please note that we are not required to agree to such a request.

Right to complain. If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy. You have the right to receive any future policy changes secondary to changes in state and federal laws.

I/We have read and received a copy of the 'Notice of Privacy Practices' and the 'Client Rights' document.

Initials ___________ Date ___________

Laura Beth Cooper, Ph.D.

FINANCIAL AND OFFICE POLICIES

Dr. Laura Cooper and the staff of this office are committed to providing caring and professional mental health care to all our clients. It is understood that Dr. Laura Cooper will make every effort possible to assist the client in the resolution of his/her present difficulties but that it may become necessary for the client to alter his/her lifestyle and/or thinking patterns to successfully resolve this situation. It is also understood that there are no specific or implied guarantees that the counseling sessions will be successful and that these sessions may, of necessity, take place over a period of several months or in some instances, years. Dr. Laura Cooper uses an eclectic approach utilizing various counseling techniques.

It is understood that scheduling an appointment with our office constitutes an agreement for counseling and is considered voluntary, regardless of the appointment being made by the patient or legal guardian of the patient. The goal of both parties is to help the client improve his/her personal living skills and cope more effectively with his/her personal situation.

As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of this office is designed to clarify the payment policies as determined by the management of the office.

PRE-PAYMENT IS REQUIRED BEFORE SERVICES ARE RENDERED

We want to inform you of our financial policies. Please read each policy and initial the spaces provided. The policies are as follows:

1. _____ The Client or Guardian is financially responsible for paying funds not paid by insurance companies or third-party payers. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your initial visit to verify your policy and what it covers. It is the policy of this office to accept Medicaid as primary insurance and secondary only to Medicare. We do not accept Medicaid as secondary to any other insurance. If for some reason your claim is denied you are responsible for the full amount on the bill. Please notify us as soon as you know if you or your family members insurance changes or cancels. You are responsible for these charges.
2. _____ Fees for such services as consultations, telephone conferences, record review, letters, copies of records, written reports, and educational recommendations, etc. will be billed at an hourly rate. Additional fees for Psychological Evaluations, personality assessments and educational testing are not included in hourly fee charges. It is understood that the fee for this service will vary depending upon the test administered and the scoring and interpretation time involved. Medicaid only pays for a limited number of visits per year. Please tell the front desk if you (or child) have seen another counselor or if you (or child) has had psychological testing performed. If all of these visits have been billed, without prior notice to our office, you will be responsible for the visit.
3. ____ Cancellations less than 24 hours prior to the appointment will require a **$70 fee in order to schedule further appointments**. Insurance companies **do not** reimburse this office for missed appointments. Therefore, the missed appointments will be billed to the responsible party. Dr. Cooper does not double book appointments. She sees one patient per hour. If you do not give 24 hour notice or if you do not show up for your appointment then, Dr. Cooper cannot see anyone during that hour. This office maintains a waiting list and we attempt to fill cancelled

appointments with someone from the waiting list. Please be considerate of other people's needs and abide by this policy.

4. ____ If you No Show for two appointments, Dr. Cooper will have to approve any future scheduled appointments. If she approves the appointment, **you will be required to pay a $70 fee for each missed appointment.**
5. ____ **Dr. Laura Cooper will under certain circumstances testify or appear in court. Time spend for court appearances providing court testimony, court preparation time, or records will be billed at $200.00 per hour. Travel time will be billed at the same rate. Time spend providing court testimony and travel is NOT covered by insurance, therefore a $1500.00 retainer fee is required prior to the scheduled court date. If an appearance in court is a possibility, payment is due one week prior to the scheduled court date. Failure to notify this office that an upcoming court date is scheduled will result in extra fees or your retainer fee not being refunded.**
6. ____ All communications that occur between Dr. Laura Cooper and the client are held in strictest confidence. NO information will be released without a written authorization by the client or their guardian. However, under certain circumstances, according to Texas statutes, confidentiality may be revoked (e.g., if the client is judged to be danger to self or others, or if child or elder abuse is suspected, the proper medical or law enforcement agencies will be notified. Other situations can also revoke confidentiality, such as a court order from a judge).
7. ____ Fees for service will be explained upon request. Please DO NOT attempt to discuss fees of any sort with Dr. Cooper. Her job is to provide you the best mental health care possible. Our front staff will be happy to discuss fees for services.

All fees, expenses and other sums of money due, from the client or guardian shall be payable to: Dr. Laura Cooper at 1214 Ellis Avenue, Lufkin, Texas 75904. A receipt will be provided for your records after payment is received.

Assignment of Benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans to be paid to Dr. Laura Cooper. A photocopy of this assignment is to be considered as good as the original.

CLIENT STATEMENT

My signature attests to the following: (1) I have read this information, understand it, and consent to services for myself and/or my family; (2) I authorize Dr. Laura Cooper to release any pertinent information acquired during the course of my evaluation and treatment to my insurance company; (3) I am ultimately responsible for payment of charges for services rendered by the provider; and (4) I understand that Dr. Laura Cooper is a **proprietor in an independent practice and is not a provider in a group practice.**

____

Signature of person responsible for payment Date

____

Signed Date

____

Witness Date

Laura Beth Cooper, Ph.D.

ELECTRONIC COMMUNICATION POLICY

To maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. However, with your permission, we can send appointment reminders to you via email.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements. However, with your permission, we can send appointment reminders to you via text message.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks. If you have an online presence, there is a possibility that you may encounter my accounts by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

You are welcome to follow my professional Facebook page which can be found at facebook.com/dr.lbcooper. I post helpful articles videos and other information that you may find useful related to mental health. Please do not attempt to message me or contact me through my professional page, as I will not respond. Again, this is an unsecure form of communication and can create security risks for you.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently, it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

I have read and understand the Electronic Communication Policy.

Client Signature: ______________________________________ **Date:** ___________________________

I agree to receive electronic communications related to setting and changing appointments, appointment reminders, billing matters, and other related issues.

Client Signature: ______________________________________ **Date:** ___________________________

Laura Beth Cooper, Ph.D.

1214 Ellis Ave.
Lufkin, TX 75904-3326

(936) 637-0074 (Telephone)
(936) 637-0081 (Fax)

Authorization for use or disclosure of protected health information

Complete this form if you authorize this office to disclose your information. Please note, your information can only be released to the party you identify in this form. If you need to identify multiple parties, please complete a separate authorization for each.

Patient Name: ____ Date of Birth: ______/______/_______

Address: ________________________________ City: _____________ State:_______ Zip: ____________

I authorize **Laura Beth Cooper, Ph.D.** to disclose/receive the following information*

- Academic, Intelligence, Psychological or Vocational Testing Results
- Medical Reports, Psychological Case Notes or Reports, Progress, or Summary Notes
- Personality Profiles
- Entire Record
- Other: (Specify) ____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following dates:

______ All dates of service Specific Dates of Service: ________________________________

I authorize these records to be transmitted TO/FROM the person or organization listed:

Name/Organization: ____

Address: ____

City:____________________________________ State:___________ Zip: _________________________

Phone: (_______)_________-________________ Fax: (_______)_________-________________

If faxing or mailing the Release of Information Form please include a copy of a photo ID such as a State issued Driver's License, State issued ID card, or passport.

Parent/ Guardian Signature: ____ Date: __________________

Printed name of Client (or Legal Guardian) and Relationship to Patient: ____________________________

Type of ID presented: ____ ID # ________________________

Signature of witness: ____