Thrive Within Psychological Services, LLC
Kimi L. Carson, PhD
1006 24th Ave, NW, Suite 100, Norman, OK 73069
Phone:(405) 321-0303 Fax: (405) 801-2846
www.normanpsychology.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____

City_____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Ok to leave a voicemail? ☐ Y ☐N

Email:_____ Would you like to receive emailed appointment reminders? ☐Y ☐N

Emergency Contact: _____ Phone: _____ Relationship to patient:_____

Who may I thank for referring you to me: _____

Please list the main reasons for seeking my services:

BILLING INFORMATION:

Person responsible for payment: _____

Address: _____ City: _____ State: ___ Zip: _____

Cell Phone: _____ Other: _____ Ok to leave a voicemail? ☐Y / ☐N

☐ SELF PAY-Not filing with insurance (If self-paying, skip the rest of this form)

Insurance Company: _____ Phone Number: _____

Member / ID#: _____ Group #: _____

Policy Holder's Name: _____Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

PLEASE COMPLETE SECTION BELOW FOR ANY *SECONDARY* INSURANCE

Insurance Company: _____ Insurance Phone Number: _____

Insurance ID#: _____ Group #: _____

Policy Holder's Name: _____Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

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Client Services Agreement/Consent for Treatment

Business Policies and Procedures effective 03/01/2025

Welcome to my practice. I appreciate your seeking my services and hope that this policy and agreement answers any questions about services, policies, and costs associated with your evaluation and/or treatment here. The following guide explains the policies concerning my services, fees, appointments, billing and insurance, and confidentiality. Please review it carefully. If you have any questions, please discuss them with me during our first appointment.

Please arrive 10 minutes early for your first appointment so we can verify we have received your completed intake forms and make a copy of any insurance card(s) if we are filing with insurance for you.

Also, we have a small waiting room that is shared with several other therapists. Please try not to bring more than 2 family members with you in addition to the patient who is scheduled.

Psychotherapy Services

I will conduct an initial evaluation session that lasts approximately one hour that may be followed by about 1 to 2 additional 45 to 55 minute sessions to develop a treatment plan and decide if I am able to provide the services that you require. This "diagnostic period" typically involves taking a detailed history, including the current difficulties that brought you to seek therapy. During this initial period, we will decide together if I am the best person to provide the services you will need to meet treatment goals. Should I be unable to provide the level or type of service you require due to my scope of practice and/or the model of practice offered here, I can provide other referral sources where you may seek out mental health services. If therapy begins, I will usually start by scheduling one 55-minute session per week, at a mutually agreed upon time, although sessions may be longer or less frequent, depending on patient needs. Should your needs or treatment goals change during the course of therapy that are beyond my scope or the scope of this model of practice, I may recommend transferring to another provider better suited to meet your needs. Typically, I provide time-limited psychotherapy, which may last for a few months to a few years. Should you require long-term psychotherapy due to chronic conditions or circumstances, I may refer you to another provider, should I be unable to provide this service. We will discuss this need should it occur.

Further, I want you to be aware there are both risks and benefits associated with therapy. While the goal of therapy generally is to find solutions to problems and reductions in feelings of distress, the process of receiving therapy also can involve the experience of uncomfortable feelings like sadness, guilt, anger, or frustration. There are no guarantees of what will be experienced in therapy. At the end of the initial evaluation period, I will offer you some initial impressions of what our work together will include if you decide to proceed with therapy.

Sometimes, patients may take a break from therapy for various reasons. If this occurs and I have no contact from you for 60 days, I will close your chart. Of course, if you seek future services, we will decide whether I am available and can resume therapy with you again. If you have questions about my procedures, we should discuss them whenever they arise.

Fees and Payment Procedures

A current fee schedule is listed further below in this policy guide. However, fees may vary, depending on your insurance plan. Payments are due at each visit unless other arrangements are made beforehand. Please make checks payable to "**Thrive Within Psychological Services, LLC".** Credit Cards and Debit Cards are also accepted for payment. Itemized receipts are available upon request.

Gifts

While the offer of gifts to our office or myself is always appreciated, please understand that I am unable to accept gifts of any monetary value. Some exceptions may include thank you cards, but they are certainly not expected nor required.

Medical Insurance

Services provided are covered under most health insurance policies under outpatient psychiatric treatment, behavioral health, or psychological/ neuropsychological testing. However, some companies reimburse mental health services at a different rate from other medical services. Some policies have annual deductibles to be met by individuals or the family; some set annual limits in dollars or numbers of visits allowed per year. Since benefits are so varied, **each client should review their policy carefully** and be aware of the behavioral health benefits or limitations involved. We will also have our billing service check your benefits upon scheduling your first appointment. ***These benefit checks are not a guarantee of payment by your insurance company. You may be responsible for more or less of the cost.***

You are strongly encouraged to verify your mental health insurance benefits in advance as we are often given incorrect information and may not know it until several sessions later after the first claim processes. It can take up to eight weeks for a claim to process.
Please be aware that, with psychological or neuropsychological testing, denial of the claim may occur pursuant to your own insurance company's policies, even if psychological testing or neuropsychological testing is a covered service, depending on your own insurance company's definition of medical necessity after the test results are generated. If this were to occur, you would be responsible for the cost of the evaluation.

We will file insurance claims for you, unless otherwise directed by you.

Appointments and New Patient Forms

For your first appointment, please complete the new patient forms issued to you via my patient portal through Therapy Notes® as soon as possible so that I may have time to review the information prior to your appointment. These forms are completed online and sent back electronically. If you require hard copies of the forms to complete, please let my Office Manager know. Failure to have your completed and signed forms ready at the time of the appointment could result in a cancellation and rescheduling of your appointment.

Phone Sessions and Other Methods of Communication

Please be aware that I do not, except in very rare instances, conduct phone sessions with therapy patients or patients undergoing psychological or neuropsychological evaluations. All communications with me are to occur via appointment only and in the office. I do not provide any after-hours support. Should you have emergent mental health needs that require ongoing phone communication, I would suggest a referral to a practice that is equipped to provide after-hours or phone support, such as a community mental health center. Should you have any mental health emergencies outside of regular business hours, please call the mental health crisis line at 988, dial 911, or go to your nearest Emergency Room.

I do not communicate with patients via text or email except for emailing appointment reminders and administrative paperwork. This is primarily to ensure your privacy and to plan ample time for communications. I also do not communicate with patients over social media.

Psychological/ Neuropsychological Testing

For patients undergoing psychological or neuropsychological testing, I will offer **ONE** feedback appointment, up to one hour in length, to go over results and recommendations that will be billed with your insurance. Should you require or wish to have another feedback appointment, please be aware that this will be on a self-pay basis only, as it is not typically a covered service by your insurance company. You may request **ONE** copy of the psychological or neuropsychological evaluation report, which can be released to you. Should you require additional copies, you will be charged **0.30** per page printed as well as any postal costs to mail the report. I encourage you to keep a copy of the report for personal records and you may share this with outside providers if you wish.

I will not provide additional communication with family members or outside providers, separate from this feedback appointment. It is required that the patient be present for all communications with family members, unless the patient lacks capacity and has a legal guardian who is able to provide court documentation to verify this.

Psychological/ Neuropsychological testing has some potential risks and complications. The process may be stressful for the person undergoing evaluation. It may create uncomfortable feelings, and the results may produce some psychological distress should a difficult diagnosis result. It has some inherent limitations; should the validity of the test results be in question, due to outside factors (e.g., fatigue, test anxiety) it may also be possible that a firm diagnosis cannot be reached. A potential consequence of psychological/ neuropsychological testing may be a recommendation for

guardianship/ proxy decision-maker should the patient undergoing testing be found to lack decisional capacity and/ or be judged unable to care for themselves and the provider may be obligated to make a report to Adult Protective Services (APS) and/or communicate to a designated next-of-kin or designated proxy decision-maker. Limitation to confidentiality covered in other portions of this consent also applies to patients receiving psychological/ neuropsychological testing services. Should there be safety concerns due to testing results (e.g., an individual is judged unsafe to drive or care for themselves/ others or safely be alone), recommendations may be made to limit or stop some activities.

Letters/ Requested Forms

Letters/ forms requested for some needs (e.g., reasonable accommodation requests, academic accommodations, disability forms) may be completed by me on a case-by-case basis and would be subject to the fees described below. If I feel that this is beyond the scope of my practice, I may refuse to complete this service.

Forensic/ Legal Work

I do **NOT** provide any services related to forensic or legal needs. Should I receive a court order to release records or testify in court, please be aware that you will be responsible for my legal fees at $500 per hour. Should you be a psychotherapy client, we would also end our psychotherapy relationship, as being a legal consultant is in conflict with the therapist-client relationship. If that were to occur, I would be happy to provide a referral for you. Should you request that I send a report of a psychological/ neuropsychological evaluation to an attorney, I will not complete this request, but you will be provided with a copy of the report at the feedback appointment, that you may share with outside parties if you wish. I am unable to provide any statements related to fitness for parenting/ adoption, fitness for duty, and ability to return to work as this is beyond the scope of my practice. I also do not provide services related to mandated therapy by any state or federal entity.

Confidentiality and Privacy Information

Records of your service activities are confidential and will not be released without the client's/ patient's specific written consent, except under the exceptions listed below. We may use or disclose your Protected Health Information (i.e., information in your health care record that may identify you) for treatment, payment, and healthcare operations purposes *with your consent*. You may revoke such consent in writing at any time. You may not revoke an authorization to the extent that (1) We have already acted, in reliance on the authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

The exceptions to confidentiality are as follows:

1. If the therapist/psychologist suspects that child abuse or neglect has occurred or that a vulnerable adult has been abused or neglected, the law requires that it be reported to the proper authorities. This includes suspected mental or emotional abuse of a child who has witnessed domestic violence.

2. If the therapist/psychologist believes that you are a clear and imminent danger to yourself or another person, the therapist may notify appropriate others to prevent that occurrence. (Examples, statements of suicidal or homicidal intent).

3. If it becomes necessary to contact an attorney or a collection agency typically due to nonpayment of bills, then your name, identifying information about how to reach you, and amount owed will become available to these agents.

4. In legal proceedings, patient/therapist communications are privileged with the following exceptions. A judge's court order is required for such information to be released or the patient's written release for the information. Examples of when a judge might subpoena your record include:

- If your mental status is an issue for any legal proceedings.
- The judge feels that communication is necessary for the proper administration of justice.

Minors/ Parents

Please be aware that I do not provide services for minor children. Should a teenager (18 or older) or young adult receive services, please be aware that I do not communicate with parents/family members for the patient/client unless the patient/client is present for that communication and requests this communication in a feedback session or therapy session scheduled in advance and by appointment only.

No-show/ late cancellation

If a session is cancelled late and/ or you no show, you will be subject to the fees outlined below. Should you no-show for an appointment, whether it be a psychological/ neuropsychological testing/ feedback appointment or a psychotherapy session or intake, additional sessions with me may be cancelled.

Court Testimony and Legal Involvement

As noted above, I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes. Should I be required to provide any documentation or service due to a court order, the client/ patient may be subject to my legal fee, which is outlined above. My services are limited only to enhancing the health and functioning of my clients. If you are seeking a psychologist who can testify on your behalf, such as in a custody or criminal case, I can refer you to other professionals who do provide that service.

By signing this agreement and beginning your treatment you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and/or oral testimony cannot be compelled in any case. If a court order (subpoena signed by a judge) is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs and/or expenses incurred for the time required to comply with or quash the subpoena, and for my time related to dealing with the subpoena.

Because of the difficulties inherent in legal involvement, I charge $500.00 per hour of time spent on preparation, travel, consultation, appearance, etc. and require that a four-hour minimum retainer be paid in advance.

Impairment from Alcohol or Other Substances

I respectfully request that you be free of alcohol or other intoxicants prior to coming in for therapy/ testing so that we can have the best chance of being successful in our work together. If, during a session, I come to believe that you are impaired in some way because of substances, then I will address that concern to determine if we can continue. If in fact you are "intoxicated" for whatever reason, then we will stop the session, and I will arrange for you to get back to your residence "safe and sound." This may involve calling a friend, relative, or a taxi. Then too, I will request your car keys so that you will not be tempted to continue driving while impaired. If, for some reason, you refuse to cooperate, then I could be forced to call the authorities to ensure your safety and the safety of others.

Emergencies

In the case of a life-threatening emergency call 911 or proceed to the nearest emergency room. Please be aware of my phone policy as above. I provide no after-hours or emergency services. All services with my are by appointment only.

Fee Schedule

Initial Diagnostic Interview, 60 minutes.....$250.00

Individual, Couples or Family Therapy, per 45 to 55-minute session.....$185.00

Psychological/Neuropsychological testing, feedback and report writing per hour (an "hour" is 31 minutes or more) ….……$185.00

Any additional consultation or services performed on behalf of the client *other than* court-related/legal matters, per hour……...…….$185.00

No Show or Late Cancelation (appointments cancelled less than 24 hours ahead of time) ….....$75.00

Letters/ forms regarding patient care, treatment or other reason ……..…….……$40.00 for the first 30 minutes, then $50 per hour for preparation and writing (an "hour" is 31 minutes or more).

Forensic/Court-Related Services …….……..….. $500 per hour, 4-Hour minimum paid in advance.

As noted above, I don't do court-related services except when someone has broken this agreement with me and I am compelled by the court to become involved with court-related matters (e.g. testifying in court under subpoena, participating in a deposition, preparing for court services, consulting with my personal attorney due to being compelled to be involved in court-related matters

**Please note that if we are filing with an "in-network" insurance your fee may differ slightly from those fees listed above.

Late Cancelations, Missed Appointments, and Payments:
When an appointment is made, that time is set aside for you and cannot be given to any other client/patient. It is very important that appointments be kept. If an appointment time needs to be rescheduled or canceled, please call the office so that the time may be made available to someone else. If you are unable to keep an appointment, kindly give a minimum of 24 hours' notice, otherwise a charge of $**75.00** will be incurred. Insurance will not pay this fee. The client or their guardian is responsible for the payment of this fee.

Unless other arrangements are made beforehand, services will be suspended/discontinued for missing payments with no notice or for no payment on two consecutive sessions until the account balance is paid. Payments are collected on the day of services unless prior arrangements are made with our office. Finance charges are also typically added if you do not make a payment within 30 days. Late charges are computed at 1.5% monthly (18% annually) for any balance over 30 days old. Accounts that are over 90 days overdue are turned over to a collection agency. ***A $50.00 charge is added for any returned checks.***

Practice Statement:
My office is in the Aurora Professional Center, a building shared with several other mental health professionals. This group is an association of independently practicing professionals, who share certain expenses and administrative functions. While the members share office space and expenses, my practice is completely independent in providing you with clinical services and I am fully responsible for those services. My professional records are separately maintained, and no member of the group will have access to them without your specific, written permission, or in the case of emergency coverage during my absence, which you request. You should be aware that I employ office staff to assist me with running my practice and I also contract a billing service to provide insurance billing services. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing.

All staff members have been given training in protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. I may occasionally find it helpful to consult with other health and mental health professionals about a case to provide optimal care to my patients. During such consultations, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important in our work together. I will note all consultations in your clinical record.

Psychologist's Duties under HIPAA
You are required under HIPAA to review my Notice of Privacy Practices which is a separate document in addition to this one. This notice is always located in the binder on the front reception desk so that you can review it at any time and also on my website: https://normanpsychology.com. You can also request a hard copy of the notice from my receptionist. We are required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to your records. We will abide by the terms in this policy unless we notify you of changes. You will be provided with copies of new/updated policies or procedures. Further, you should be aware that pursuant to HIPAA and the professional ethics code, I keep professional records containing your Protected Health Information in parts of your file.

Breach Notification Addendum to Policies and Procedures: As Required under the 9/2013 Privacy Rule of HIPAA, I must notify you of the following Breach Notification Policy. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule.

1. When the Practice becomes aware of or suspects a breach in your PHI, the Practice will conduct a Risk Assessment and will keep a written record of that Risk Assessment. This will include reviewing the nature and extent of the PHI involved, to whom the PHI may have been disclosed, whether the PHI was in fact acquired or viewed, and the extent to which the risk to the PHI has been mitigated.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach as described in the breach notification overview in my Privacy Notice.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will review its privacy and security practices to determine what changes should be made to prevent any re-occurrence of such breaches.

Consent for Treatment

Your signature below indicates that you have read the information in this agreement and agree to its terms. This also serves as an acknowledgement that you have received and reviewed the HIPAA Privacy Notice form described herein.

X_____ _____ _____

Patient Signature | Printed Name of Patient | Date

Consent for Release of Information for Medical Billing

I give permission to **Thrive Within Psychological Services, LLC**., their staff, or their medical billing company to release medical information to my insurance company or a managed care company contracted by my insurance company to manage my medical care, if necessary. I understand this allows the insurance company to pay for their portion of services provided at this office. I further agree to pay for any services that the insurance does not cover and/or will not pay for.

X_____ _____ _____

Patient Signature | Printed Name of Patient | Date

If you have any questions about your privacy rights or this business policy and agreement, please direct them to:

Thrive Within Psychological Services, LLC
1006 24th^h^ Ave, NW
Suite 100
Norman, OK 73069
405-321-0303.