VICTORIA J HAAG, RN, MS, LCMFT

Find Direction for Your Life . . .

PATIENT NAME _____ **DATE of BIRTH**_____/_____/_____

INFORMATION AND AGREEMENT FOR SERVICES

My practice was founded to promote the healing and growth of individuals, marriages, and families through clinically sound methods of therapy and education. The following information is provided to avoid misunderstandings and to facilitate a therapeutic relationship with me. Each family member, 13 years of age and older in the patient family, should read and sign indicating acceptance of these terms for service.

YOUR THERAPIST

I, Victoria Haag, hold a Masters Degree in Family Therapy; am licensed by the State of Kansas;, and am a Registered Nurse. I am committed to uphold the ethics of the counseling profession, which demand strict confidentiality and the highest regard for the value of your time, finances, and person.

CONTACTING YOUR THERAPIST

My direct line telephone number is (316) 250-9057. If I am not immediately available, you may leave a message with the assurance that I check and respond to messages regularly. I do not answer the phone while with a patient, but will return your call at my earliest convenience.

CRISIS or EMERGENCY SITUATIONS

If you have an emergency after office hours, you may contact me by calling (316) 250-9057. If you are in imminent danger, get to a safe place, call 911, and then call me at the above number.

OFFICE HOURS

Business office hours are 8:00 A.M.–5:00 P.M., Monday through Friday.

APPOINTMENTS

Appointments are generally scheduled between 45 and 60 minutes. Childcare is not provided, and for safety reasons children may not be left unattended in the waiting area. Therefore children brought with you to your appointment must be included in the session. If you must reschedule, please notify me as far in advance as possible.

PUNCTUALITY

I make every effort to begin and end appointments at scheduled times. Occasionally I may be responding to an urgent situation or emergency, which may cause your session to begin late. However your session will still be the scheduled length. If you arrive late for an appointment, the session will still end at the time it was scheduled to end. The charge for a shortened session will be the contracted fee.

MISSED APPOINTMENTS

To be effective, counseling and psychotherapy need to take place on a regular basis. The best results occur when appointments are scheduled and attended regularly. Because each appointment time is reserved specifically for you, it is necessary for me to charge for appointments that are missed or cancelled less than 24 hours in advance. If there are circumstances that both you and I define as an emergency, or otherwise unavoidable, the charges may be waived. These charges are not covered by insurance and are your responsibility.

CONFIDENTIALITY and PRIVACY PRACTICES

Federal and state laws and regulations protect the confidentiality of mental health information and records. Violation of confidentiality is a crime. By signing this agreement you are authorizing me to use and disclose your mental health information for the purposes of **treatment**, **payment**, and **health care operations** as outlined in the **Notices of Privacy Practices**. This document is available on my website or you may obtain a personal copy from me. I encourage you to review this information and ask any questions you may have.

COMMUNICATION

Your appointment reminders and other treatment related information will be communicated with you as you have indicated on the Patient Information form. Statements of your account and other information may be mailed or emailed to you. Please be aware that these tools may be relatively easily accessed by unauthorized people and may compromise the privacy and confidentiality of such communication. Please tell me if you wish to use some other communication arrangement.

PATIENT RIGHTS & RESPONSIBILITIES

- You have the right to be fully informed about fees for therapy and the methods of payment available.
- You have the right to ask questions about your therapy. At your request, I will explain my therapy approach and methods used, as well as the Code of Ethics under which I practice.
- You have the right to specify and negotiate therapeutic goals and to renegotiate when necessary.
- You have the right to end therapy at any time without moral, legal or financial obligations, other than those already created. If you make a decision to stop therapy, I request that we schedule a final session to explore your decision and to summarize what you have accomplished. If a referral to another therapist is desired, it will be made for you at this time.
- You have the responsibility to provide me with accurate information as to how I might best help you, and to keep me advised of your needs throughout the therapeutic process.

THERAPY PROCESS

In working to achieve the potential benefits of therapy, it may require that you make firm efforts to change and may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings such as fear, anger, depression, frustration, and hurt. Seeking to resolve issues between family members, marital partners, and in other relationships, can also lead to discomfort, as well as changes that may not have originally been intended. The results of therapy vary and no promises are made to you regarding the results of the treatment provided.

CASE CONSULTATION

As part of providing quality care, I may on occasion discuss general case information with a colleague or professional consultant. Specific identifying details will not be included.

PRIMARY CARE PHYSICIAN OR PSYCHIATRIST

Under Kansas law, I am required to consult your primary care physician or psychiatrist to determine if there is any medical condition or medication that is contributing to your presenting symptoms, and to coordinate delivery of healthcare services

MD Name: _____ City_____ Phone_____

To waive the required consultation with your primary care physician or psychiatrist, sign here: _____

(If you do not sign the blank, you are granting permission for me to both secure information from your physician or psychiatrist and release pertinent therapy information to them to coordinate your care

PROFESSIONAL FEES

It is my responsibility to notify you of your financial responsibility. As a Licensed Clinical Masters Level Therapist, my traditional, stated fees are:

*Initial Session: $175 Subsequent Sessions: 16-37 minutes: $80 38-52 minutes: $150 53+ minutes: $170

** Fees are higher for the first session due to the extra time involved in the intake process for a new patient.*

Subsequent fees depend on the length of the session, as indicated above.

Phone calls discussing issues with me are billed at your session rate when over 10 minutes in length. Payment is due at the next scheduled appointment. Additional services on your behalf will also be charged at your session rate. These services may include, but are not limited to, hospital visits, consultations, home visits, research, preparation of letters, reports or other material, responding to a subpoena, and preparation for and appearances at depositions and court hearings, which includes travel time and time waiting to testify. Payment, or a deposit, will be required in advance for legal/court associated activities

PAYMENT OF FEES/COPAYS ARE REQUIRED PRIOR TO THE BEGINNING OF SESSION

I will bill your insurance after first collecting your copay, deductible, and/or other fees for which you are responsible. If you have secondary insurance, I will make an individual determination regarding the handling of that policy. **The fee for missed appointments is $60.**

According to information provided by your insurance, your policy is to cover the following:

_____

You are responsible for: _____

You, the patient, agree to the following:

1) Give Victoria Haag permission to release information obtained during assessment or treatment for the purpose of supporting my insurance claim on your behalf and/or securing timely payments due the assignee.
2) Assign mental health benefits, including those from government-sponsored programs, to be paid to Victoria Haag.
3) You are responsible for all charges, regardless of insurance coverage

ACCEPTED METHODS OF PAYMENT

Cash, Check, Money Order, Cashier's Check, Traveler's Check, Debit Card, Credit Card (Visa, MasterCard, Discover), some medical savings cards. Cards are encrypted and processed into the secure practice management system. Payments are credited directly into your account. Insufficient fund checks will be assessed an additional fee of $30, payable at the next scheduled appointment. Please complete the attached form to charge your debit, credit, or health savings card for each service.

CONSENT FOR TREATMENT OF MINOR CHILD

Therapy can be a very important resource for a child. Establishing a therapeutic relationship outside of the home can provide an emotionally neutral setting in which a child can explore feelings and experiences that are impacting his/her life. It is my primary responsibility to respond to your child's emotional needs. To do that, you are requested to give permission for the following:

- For me to meet with your child in therapy with or without your presence, whichever I determine would be the most beneficial for the child
- For me to reveal or withhold information that in my judgment is necessary to best help and protect your child.

I am legally obligated to report to the proper authorities concerns I may have regarding the safety of your child, if the necessity. When possible, I will advise you regarding my concerns prior to a report being made. This authorization may be revoked at any time; however, prior to revocation, therapy will be conducted as above. Unless revoked, this Authorization will be in force for a year following the cessation of treatment.

PATIENT ACKNOWLEDGEMENTS Please check the appropriate boxes:

- ☐ I understand that I have reviewed or may request a copy of the complete Notice of Privacy Practices and/or Information and Agreement for Services
- ☐ I am authorizing Victoria Haag to consult with a colleague as needed, without disclosure of identifying information.
- ☐ I agree to communication of treatment information and appointment reminders as set forth on the Patient Information form.
- ☐ I agree that any information that was not clear to me regarding my agreement for therapy, financial responsibility, confidential/privacy have been explained to my satisfaction.
- ☐ I/we agree to the provisions for treatment of a minor.

Patient Signature_____ and/or Responsible Person_____

Relationship to Patient_____

I have presented the issues above to my patient(s). My observations of his/her behavior(s) and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent.

Therapist Signature_____ Date _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ Health Savings ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVV_____ (3 digit code on back of card)
Expiration Date (mm/yy): _____
Cardholder ZIP Code (billing address on file with credit card company): _____

I authorize Victoria Haag, RN, MS, LCMFT to charge my card for agreed upon services. I understand that my information will be securely encrypted to file for future transactions on my account.

_____ _____

Customer Signature Date