Isaac G. Martinez, Ph. D., PLLC
109 Falls Court, Suite 600
Boerne, TX 78006

Phone (830) 428-0944
Fax (830) 331-9922

CONFIDENTIAL INFORMATION

(PLEASE PRINT)

Please mark "NA" if does not apply.

Date: ____________________

Patient Name: ____

Date of Birth:_____________ Age: _________Ethnicity: ______________________________

SSN _____________________________________

School: ____________________ Grade: ___________ Teacher: ______________________

School Address: ____________________________ School Phone: ____________________

Referred by: ____

Reason For Referral:____

____

Previous Mental Health Contacts: Yes / No With Whom? __________________________

Reason?____

____

Primary Physician: ____________________________ Phone: _______________________

Date of Last Contact: ___________________ Last Physical Exam: _____________________

List any Medical Problems: ____

List Current Medications: ____

List any Allergies: ____

Parent/Guardian OR Emergency Contact Information

Name/Relation:___________________________________SSN:________________________

Home Address: ____

City/State/Zip: ____

Cell Phone:_______________ Work Phone:_______________ Home Phone: ____________

Education Level: _____________________Occupation:______________________________

Employer: ____

Work Address: ____

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INFORMED CONSENT

Session Duration: An initial visit lasts 60-75 minutes. A follow-up adult individual session lasts 50-60 minutes. Follow-up individual child/adolescent session lasts 50-60 minutes. Family sessions last 50-60 minutes.

Payment of Fees: Payment for services and copays are expected at each visit. This office will bill *contracted provider* health insurance claims, however, the client, not the insurance company, is responsible for payment of the bill. If you are using another insurance company our office will fill out the insurance information on the required form and provide any additional information you may need for you to submit information to your respective insurance company. Please note that insurance companies may not guarantee payment. If another arrangement is necessary, please consult with Dr. Martinez. Dr. Martinez does not participate in court-related matters. However, if court related work is required, court related work will be billed to the patient's responsible party as identified at intake at a rate of $300.00 per hour. This includes payment for time involved in preparation, communication with involved parties, depositions, testimony, standby efforts, and other costs incurred as a direct result of court cases. A minimum (5) hour flat fee will be due prior to the abovementioned services. Additional costs may be incurred if time and efforts by Dr. Martinez are above and beyond the five hour minimum fees at the rate of $300.00 per hour.

All efforts will be made to work out an acceptable method of payment with regard to the abovementioned services. If the client fails to keep the arrangement he/she has agreed upon, this office will utilize an outside collection agency to collect delinquent accounts.

Fee Schedule

Service	Fee
Initial Intake	$175.00 per session
Individual Therapy	$150.00 per session
Family Therapy	$175.00 per session
Telephone Consultation	$ 40.00 per 15 minute call
After Hours/Holiday Phone Consultation	$ 80.00 per 15 minute call
Written Notes by the Psychologist for non-legal purposes	$ 35.00 per 15 minutes
Legal/Court-Related Work	$300.00 per hour

No Show Fee (Cancellation or Reschedule) without 48 hour notice $150.00

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Methods of how may contact you:

Home Phone:	Work Phone:	Cell Phone:
May we leave a message? ☐ Yes ☐ No	May we leave a message? ☐ Yes ☐ No	May we leave a message? ☐ Yes ☐ No

Cancellation/Reschedule Policy: If you need to cancel or reschedule an appointment, please notify Dr. Martinez as soon as possible. ***A missed appointment without a 48 hour notification will be charged a "No Show" fee.***
Missed appointments are charged at the *regular appointment fee* and cannot be billed to your insurance company. If the missed appointment is scheduled for testing then a rate of 150.00 will be charged for a missed session without 48 hour notice. At times the doctor may have to cancel and/or re-schedule an appointment due to unforeseen circumstances and will make every effort to inform you in a timely manner.

Termination of Doctor-Patient relationship: Failure to follow the discussed treatment plan, failure to keep routine appointments, failure to meet financial obligations may result in termination of services. Please discuss other reasons for referral and termination with your doctor if you have questions. Medical records will be provided to your physician upon receipt of signed medical release form with a written request.

Confidentiality: All information and records will be kept confidential. These records will be held in accordance with state and federal laws regarding confidentiality of such records and information. However, records and/or information will be released regardless of consent under the following circumstances:

1. According to state and local laws, therapists are legally obligated to report to the appropriate agencies all cases of physical or sexual abuse or neglect of minors, disabled persons or the elderly.
2. According to state and local laws, therapist must report to the appropriate agencies all cases in which there exists a danger to self or others.
3. When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.
4. In the event that a patient is in need of emergency services and other medical personnel need to be contacted.
5. If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.
6. Patient information will be released to insurance providers for billing and insurance purposes.
7. The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
8. The therapist is legally obligated to release the client's therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist.

Professional Records: The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client's consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client's request.

Treatment of Minors: I see patients starting at age 9. Treatment of children under the age of 18 years will be provided only with the consent of the legal guardian or parent, I expect adults to accompany their children to appointments. Please do not leave your child unattended in the reception area, as I cannot be responsible for their well-being. Payment for services rendered to minors is the responsibility of the adult.
By signing this consent form, the client acknowledges that he or she is the guardian (as established by the state or the divorce decree) of any minor presented for treatment. A copy of the custody agreement in the cases of divorce must be provided.

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will provide more specific information as approved by the adolescent client and parents. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.
PLEASE NOTE: The psychologist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

Emergency/On Call Services: If you are in need of emergency services, please go to the nearest hospital emergency room or call 911. Dr. Martinez can be contacted by leaving a message on his confidential voicemail or with his receptionist at the main office (830) 428-0944. Calls will be returned as soon as possible or by end of the next business day.

Therapy and Testing Services: Dr. Martinez' approach to psychotherapy involves an eclectic approach utilizing cognitive-behavioral, social learning, biopsychosocial, and humanistic principles. There are a number of factors that may lead to both unsuccessful and successful treatment experiences. If at any time you have questions or concerns about your treatment experience with Dr. Martinez please feel free to bring up these issues in therapy. Treatment is viewed as a collaborative event in which both the therapist and client should work toward a common goal. If Dr. Martinez is treating your child or adolescent, parents are required to participate in their treatment.

Testing services are available. Please consult with Dr. Martinez about the nature of the question to be addressed in the testing. Further information about testing will be provided prior to outset of psychological or neuropsychological testing.

Risks and Benefits of Psychotherapy: Psychotherapy may have risks. Psychotherapy often involves sharing unpleasant aspects of your life and you may experience uncomfortable feelings such as sadness, anxiety, guilt, anger, and frustration. Because of the changes you might make as a result of our collaboration, your relationships with others may change and this may cause distress in these relationships. On the other hand, psychotherapy has been proven to have multiple benefits. Although there are no guarantees of what you will experience, therapy often leads to feelings of self-fulfillment, improved relationships, solutions to problems, and diminished feelings of discomfort.

Risks and benefits of Testing: People who undergo psychological testing may experience the same types of reactions as described in the previous section on risks of psychotherapy. However, psychological testing can be an important aspect of assessment in helping providers determine diagnosis and treatment planning considerations.

Diagnostic Considerations: People who undergo psychotherapy or testing will receive a diagnosis as with any other "physical diagnosis". Behavioral health diagnoses are derived from the Diagnostic and Statistical Manual of Mental Disorders 5th Edition currently referred to as the DSM-5. Insurance companies use these diagnoses as a basis for medical necessity and other insurance related functions. Some diagnoses may not be reimbursable. A diagnosis may also have an effect on life insurance and medical insurance coverage depending on the nature of the diagnosis. Be sure to review your respective policies and other pertinent coverages to make yourself aware of any potential outcomes of a diagnosis. Also be sure to discuss any concerns with Dr. Martinez.

FEDERAL HEALTH INSURANCE PORTABLITIY AND ACCOUNTABILITY ACT (HIPAA)

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Emails will become part of the client record and are not encouraged. The therapist may elect to not accept emails from the client when it is determined to be in the best interest of the client.

CONTINUED ON NEXT PAGE

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Your signature indicates that you have read this document and consent to treatment/testing and financial policies. Please note that insurance companies do not pay for no show fees, telephone consultations and written notes by the psychologist for non-legal purposes. This is the responsibility of the patient or responsible party. This will serve as a contract between you and the provider:

____

Client Signature Date

____

Client Printed Name Date

If client is under 18, parent/guardian consent is needed.

____

Parent/Guardian Signature Date

____

Parent/Guardian Printed Name Date

____

Witness Date

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FINANCIAL RESPONSIBILITY AND PATIENT INFORMATION

As a courtesy to you, I will give you an itemized statement for you to send to your insurance company for the day of your appointment.

If you are uncertain about what your insurance company covers for psychiatric benefits, I recommend **you call them to verify and explain your benefits.** Services I provide may be considered "non-covered services" by your insurance plan. Regardless of your insurance company's arbitrary determination, you are responsible for payment of services at the time of your appointment.

Minors: I see patients starting at age 9. I expect adults to accompany their children to appointments. Please do not leave your child unattended in the reception area, as I cannot be responsible for their well-being. Payment for services rendered to minors is the responsibility of the adult.

Missed Appointments: If you need to cancel an appointment, please give 48 hours notice, if you do not cancel your appointment 48 hours in advance, you will be charged your regular fee.

Returned Check Fee: Please contact my office immediately upon notification of a NSF check. My office will charge a $25.00 fee for bad checks. Your check will be re-deposited after two days unless you notify my office otherwise.

Financial Arrangements: If you are experiencing difficulty meeting your financial obligations for any reason, please speak with me about your concerns. I will try to work out an arrangement that will make it possible for you to meet your financial obligations. However, if you refuse to pay for services rendered or to make a financial arrangement, I send open accounts to collections.

My signature below indicates that I have read and agree with the above financial policy and payment agreement.

______________________________________ ________________________

Patient Signature (or responsible party) Date Signed

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Billing and Insurance Information

Person responsible for Payment:

Subscriber's name:________________________________ Date of Birth ____/____/____

Home #: (_____) _______________ Subscriber's SSN:____________________________

Occupation:_________________________ Employer:______________________________

Relationship to client: Self ____ Spouse ____ Child _____Other__________________

Insurance Information: ***Please present insurance card to for copying upon arrival.***

Primary Insurance:____

Identification #______________________________ Group #________________________

Insurance Company's Telephone Number: (______) _________-___________________

Subscriber's relationship to client: Self____ Spouse____ Child ____ Other ___________

Secondary Insurance:____

Identification #___________________________ Group or Plan #____________________

Insurance Company's Telephone Number: (______) __________-__________________

Subscriber's name:________________________________ Date of Birth ____/____/____

Subscriber's relationship to client: Self____ Spouse____ Child ____ Other ___________

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to **Isaac G. Martinez, Ph. D., PLLC** and understand that I am financially responsible for non-covered services. I also authorize **Isaac G. Martinez, Ph. D.** to release any information to my insurance company required to process claims.

Signature of Client:_______________________________**Date Signed**:______________

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Private Pay Acknowledgement

I acknowledge that I am requesting services from Isaac G. Martinez, Ph.D. on a private basis. I am acknowledging that I do not currently have insurance coverage that Dr. Martinez is contracted with, or if I do have insurance, I am not choosing to claim these services. I have also declined to provide any insurance information to Dr. Martinez or her staff. I understand that if I do choose to use my insurance coverage in the future that services previously rendered will not be eligible for coverage or back billing.

Date: _______________

Patient's/Guardian's Printed Name: __________________________

*Patient's/Guardian's Signature:*______________________________

---

*Witness Printed Name:*____

*Witness Signature:*____

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Notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act I am required to provide you with this information regarding my responsibilities to you regarding how your psychological and medical information may be used and disclosed and how you might get access to this information. It is intended to clarify these responsibilities and right. Please ask if you have any questions.

The notice of Privacy Practices has been provided to me prior to my signing this consent. The Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI). I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in the treatment.*
- *Obtained payment for that treatment.*
- *Conduct normal healthcare operations.*

The practice explained to me that the Notice will be available to me in the future at my request and explained my right to obtain a copy of the Notice prior to signing this consent.
The practice reserves the right to change its privacy practices that are described in its Notice of Privacy Practices.
I understand and consent to the following appointment reminders that will be used by practice:

- *Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.*
- *The Practice may use and/or disclose my PHI, which includes information about my health or condition and the treatment provided to me, in order for the practice to treat me and obtain payment for that treatment and as necessary for the Practice to conduct its specific health care operations.*
- *I understand that I may request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to the requested restriction, then the restriction is binding on the Practice.*
- *I understand that this consent is valid for 2 years. I further understand that I have the right to revoke this consent, in writing, at any time for all further transactions, with the understanding that any such revocation shall apply to the extent that the practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.*
- *I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Notice, then the Practice will not treat me.*
- *By signing this form, you acknowledge that this medical practice has given you a copy of its Notice of Privacy Practices. This notice explained how your health information will be handled. HIPPA, the new Federal Law concerning medical privacy, requires this notice.*

I have received a copy of the Notice of Privacy Practices. The Practice of Dr. Isaac G. Martinez has given me the opportunity to ask any questions about this notice and my questions have been answered.

Patient's/Guardian's Signature *Date Signed*

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*****PROVIDER USE ONLY*****

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below:

Patient was given the notice: ___________yes _________no

Reason signature was not obtained:

____

____

Staff Signature *Date*

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, SCHOOLS & PRIMARY CARE PHYSICIANS

Patient: ________________________________ Date: ___________________________

DOB: __________________________________ SSN: ____________________________

I request and authorize the office of Isaac G. Martinez, Ph. D., PLLC. to release healthcare information for the patient named above, to the following: Family, Friends, School and/or Primary Care Physician as listed below:

Name: ___________________________________ Relationship: ___________________________

Name: __________________________________ Relationship: ___________________________

School Name:
____

Primary Care Physician: ____

Psychiatrist: ____

This release and authorization applies to the following (check all that apply):

____ All health care information
____ Only dates of service from _______________ to ___________________
____ Only information pertaining to the treatment of ________________________
____ Mental Health Information, Mental Retardation Information
____ Alcohol/Drug (substance) information
____ HIV/AIDS information
Other ____

*I request that information **NOT** be released to the individuals listed below:*

Name: ______________________________ Relationship: _______________________________

Name: _______________________________ Relationship: ________________________________

*This authorization expires when revoked by me **IN WRITING** whichever occurs first. If I revoke this authorization, I do understand that information may have already been released by the doctors named in reliance on my original authorization.*

________________________________ __________________________ _______________
Patient's/Guardian's Signature *Relationship* *Date*