Sculpt Your Mind And Body

Client Financial Agreement

CANCELLATION AND MISSED APPOINTMENT POLICY

I understand that my appointment time is reserved for me at the exclusion of others who may be waiting to see Dr. Epps. I understand that if I am not able to attend my appointment, I must give 24-hours advance notice to cancel the appointment without being charged. If I cancel on the day of my appointment, my account will incur a $100.00 fee and if I fail to show without any advance notice, my account will incur a $100.00 fee. I agree to call or text the office at 432-653-4281 if I need to cancel or reschedule my appointment.

FEES, PAYMENT AND INSURANCE REIMBURSEMENT

I understand that I am fully responsible for the payment of all fees for services by Becoming A Better You, LLC. I understand that if I have insurance, Becoming A Better You, LLC will file the claim on my behalf but, I understand that I am ultimately responsible for any therapy fees not covered by my insurance carrier. Co-pays and non-covered services are payable at the time of service. In the event that insurance is billed on my behalf, my signature below authorizes payment of mental health benefits to Becoming A Better You, LLC.

I understand that it is Becoming A Better You, LLC's policy that the fee for any session is payable at the beginning of the session. All sessions are 50 minutes in length (longer sessions may be available for an additional fee). The fee for a therapy session is $180.00 for private paying client and there is a slide scale fee offered based upon my income. Should you request a copy of your counseling records, please be advised there is $105 record preparation fee. (And a "Release of Information must be signed documenting that I am releasing your records to you).

My signature below indicates that I have read, understand, and agree to the statements made in the Client Financial Agreement regarding Cancellations and Missed Appointment & Fees, Payment, and Insurance Reimbursement. I authorize and agree to have my credit card and information (as listed below) kept on file and charged for late canceled appointments, no show appointments and other outstanding balances on my account that I have not been paid.

By signing below, I also certify that the credit card information I am providing is accurate and I am an authorized user on the credit card account.

Client name [please print]:_____

Client Signature: _____ Date ___/___/___

☐ VISA ☐ MASTERCARD	CARD NUMBER	EXP DATE	CVV CODE

I hereby give consent to charge my credit card any outstanding balance at the time of billable service.	CARD HOLDER NAME
CARD HOLDER SIGNATURE	DATE

Parental Consent to Treat a Minor

I,_____ (Name of Parent or guardian of child), give my permission for my child, _____ (Full Name of Minor), _____ (Birth Date or Minor) to be treated by Becoming A Better You, LLC in psychotherapy. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child; with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (Date consent expires).

_____

Parent or guardian's signature Relationship to minor Today's date

_____

Name and Address of Parent or guardian (Street, City, State and Zip)

_____

Other parent or guardian's signature Relationship to minor Today's Day

_____

Name of Address of other parent or guardian (Street, City, State and Zip)

_____

Address of minor (Street, City, State and Zip)

_____

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Fee schedule and payment requirements

Sessions are billed at $180 per session for counseling unless arrangements are requested for special consideration as provided below. If you desire your fees to be based on the sliding scale, reflecting the amount of your total annual income for your household.

ANNUAL INCOME	COUNSELING SESSION
$25,001 to $40,000	$95
$40,001 to $55,000	$110
$55,001 to $70,000	$130
$70,001 to $90,000	$140
$90,001 and $115,000	$165
$116,000 and Up	$180

Payment for a session is required at the time of service with **NO EXCEPTIONS.** Payments are payable to Becoming A Better You, LLC via Cash App, Zelle, Credit Cards and Venmo. These fees will be adjusted accordingly after each filing year, and you must provide proof of your household income to be considered for reduced fees.

If you **NO SHOW** on your appointment or you need to cancel/reschedule on the day of the appointment without providing a 24-hour in advance notification, you will be charged $100.00 for the missed appointment.

Additionally, arriving 15 minutes late after your scheduled appointment is considered a **NO SHOW** and the corresponding fee of $100.00 will be charged. Moreover, all account balances must be paid in full before therapeutic services can resume.

Signed…… Date: ……

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Limits of Confidentiality and Client Rights

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Texas. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client's legal guardian. It is the policy of Becoming A Better You, LLC not to release any information about a client without a signed Release of Information. Noted exceptions are outlined as follows:

- Signed authorization to release information to a specific individual organization.
- Therapist's determination that you may harm yourself or someone else.
- Disclosure of abuse, neglect, or exploitation of a child, the elderly or disabled.
- Disclosure of professional misconduct of another mental health professional.
- Court order or requirement by law to disclose information.
- Prenatal exposure to controlled substances.
- In the event of a client's death, the spouse or parents of a deceased client has a right to access their child's or spouses' records.
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- Insurance companies. (only information required for billing purposes)

Client Bill of Rights

Becoming A Better You, LLC does not discriminate on the basis of religion, race, gender, marital status, age sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client shall:

- Be informed prior to, or at the time of the intake appointment of services available at Becoming A Better You, LLC and of any financial charges that are the client's responsibility to pay beyond the coverage of insurance.
- Expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand
- Have the right to know the name, and the competences of, the licensed mental health professional responsible for coordination of his or her treatment.

In addition to the rights listed above, services offered by practitioners licensed by the State of Texas have the right to (a) expect that practitioner has met the minimum qualifications of training and has the experience required by state law; (b) examine public records containing the credentials of the practitioner; and (c) obtain a copy of the rules of conduct.

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

Client Name (please print): _____

Client Signature: _____ Date _____/___/_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

When Dr. Erika L Epps at Becoming A Better You, LLC consults, evaluates, diagnoses, treats, and/or refers you (the client or minor client that you represent), Dr. Epps will be collecting what the law calls "protected health information" (PHI) about you or your minor. At Becoming A Better You, LLC, Dr. Epps is very careful to keep your health information secure and confidential. The HIPAA law requires Dr. Epps to maintain your privacy, to give you this notice, and to follow the terms of this notice. The law permits Dr. Epps to use or disclose your health information to those involved in your treatment; or to disclose your health information for payment of service from your insurance company; or in an emergency. Dr. Epps may disclose your health information to a family member or another person responsible for your care. Dr. Epps may also release some or all your health information when required by the law. (please refer to Becoming A Better You, LLC "Limits of Confidentiality")

If you are concerned about your PHI, you have the right to ask Dr. Epps not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation request in writing. Although Dr. Epps will try to respect your wishes, Dr. Epps is not legally required to accept these limitations. You have the right to know of any uses or disclosures Dr. Epps may make with your health information. You have the right to transfer copies of your health information to another practice. You have the right to request an amendment or change request in writing. If you wish to include your statement in your file, please give it to Dr. Epps in writing. Dr. Epps may or may not make the change you requested but will agree to include your statement in your file. If Dr. Epps agrees to an amendment or change, Dr. Epps will not remove or alter earlier documents but will add new information.

You have the right to receive a copy of this notice. If Dr. Epps changes any details of this notice, Dr. Epps will notify you of the changes in writing. If you believe that your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services 200 Independence Avenue, S.W., Room 509F, Washington, D.C 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, Dr. Epps asks you please to discuss the matter with her beforehand.

By signing this form, you agree to Becoming A Better You, LLC **using your PHI in the manner described above. Your signature below acknowledges that you have read this notice and are aware of Becoming A Better You, LLC notice of privacy practices.**

Client Name: (please print)_____

Client Signature:_____Date_____/_____/_____

Electronic Communication and Contact Policy

IN PERSON, OUTSIDE OF THERAPIST'S OFFICE

In an effort to further protect your confidentially, if Dr. Epps sees you in public, I will only acknowledge you if you approach first as your privacy is of the utmost importance.

TEXTING POLICY

If you checked "yes" on your intake from indicating that you give your permission for Dr. Epps to contact you via text, you may be contacted to schedule confirm or cancel an appointment. Unless otherwise stated by Dr. Epps, texting should be limited to scheduling or confirming an appointment or notifying Dr. Epps that you may be running late (not more than five minutes) for your appointment. Please be advised that texting is not an appropriate method of reaching out in a crisis.

PHONE CONTACT

Outside of your regular scheduled sessions, in the event of a crisis, one brief (no more than five to ten minutes) phone call is acceptable on occasion between sessions. If more contacts are needed, you can subscribe to the Concierge Therapy Service. It is important that you first consider utilizing your therapy tools, and other support systems between therapy sessions before contacting Dr. Epps unless it is an emergency or crisis situation. For phone consultations exceeding ten minutes, you will be billed in accordance with the Client Financial Agreement. If you are suicidal or have a life-threatening situation, please call 911/988 or go to the nearest hospital.

E-MAIL CONTACT

Outside of your regular scheduled sessions, a short email (no more than a paragraph) is acceptable on occasion between sessions. If more contacts are needed, you can subscribe to the Concierge Therapy Service. Your emails should be geared toward confirming or changing appointments, and not discussing therapeutic topics, sending photos, jokes, or other such email as the relationship is of a professional therapeutic nature. Any other topics outside of this are best for your session.

RESPONSE TIME

Please allow at least 24-hours for a reply regarding routine matters. As Dr. Epps sees numerous clients per week, I receive multiple emails and calls from many clients. Please be considerate of Dr. Epps's personal time.

My signature below indicates that I have read and agree to Becoming A Better You, LLC Electronic Communication and Contact Policy

Client name (please print):_____

Client signature:_____ Date:___/_____/_____

Court Testimony and Deposition Agreement

This therapist **DOES NOT** voluntarily appear in court on behalf of individual, children, or families. Becoming A Better You, LLC services are designed to assist clients with their difficulties through individual or relational psychotherapy. Dr. Epps does not typically maintain the type of records intended for use in court.

In addition, the legal process is such that the therapist may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Therefore, because the client-therapist relationship is built on trust with foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court or to testify to whether certain matters are factual or in an expert nature, in court or deposition.

In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator or other hearing officer, or to testify at a deposition. Whether the testimony is "factual" or "expert" or is required to present any or all records pertaining to the counseling relationship to a court official or an attorney, the client agrees to pay Dr. Epps for her time and services. These billable services. include but are not limited to: travel, necessary expenditures (e.g. copies parking, meals, etc....), time spent speaking with attorney, reviewing records and preparation of reports. Becoming A Better You, LLC charges a rate of $165 per hour for court and deposition preparation plus per diem for mileage and meals, and actual expenses for hotel, airfare, rental cars and so forth.

If Dr. Epps receives a subpoena to appear in court or at a deposition on a certain date, she requires a 10-day notice to the hearing in order to cancel other Becoming A Better You, LLC clients that have already scheduled appointment for that particular date. As such Becoming A Better You, LLC will require a payment of $1000 for the entire date (10 days prior to require appearance date) when the subpoena is served. If payment and proper notice are not provided, the client agrees the subpoena is waived, Dr. Epps will not cancel standing client appointments that are already scheduled for office visits, and she will not appear in court or at the deposition. The client should notify his or her attorney of this stipulated agreement prior to signing this agreement if the client is contemplating using Dr. Epps for court appearance or deposition.

Initial one of the following

____ I AM seeking for court testimony or court involvement on behalf of my therapist Becoming A Better You, LLC

_____I AM NOT seeking for court testimony or court involvement on behalf of my therapist at Becoming A Better You, LLC.

By signing this form, you acknowledge you have notified Becoming A Better You, LLC (*before* a counseling relationship is established) that you and/ or your child are not attending for court or court related purposes/motivations. Furthermore, you agree to the stipulations of this agreement and will abide by the agreement as stipulated.

Client name (please print)**:**_____

Client signature_____Date:_____/____/_____

Therapist signature:_____ Date:_____/_____/_____