**Let It Rain Psychotherapy, PLLC**
**Rayné Johnson, LCSW**
**Family Therapy Intake and Informed Consent**

Family Last Name: ______________________________________________ Date: ____________________

**Family Member Names:**
Parent ____________________________________________DOB _________________ Age_____________
phone: ____________________________ address: ________________________________________________

Parent ___________________________________________DOB _________________ Age _____________
phone: ____________________________ address: ________________________________________________

Child______________________________________________DOB _________________ Age _____________
Where does this child reside? _____________________________________________________________

Child______________________________________________DOB _________________ Age _____________
Where does this child reside? _____________________________________________________________

Reason for seeking family therapy: ____________________________________________________
What do you hope to accomplish in family therapy?
1. ___________________________________________________________________________________
2. ___________________________________________________________________________________

Has anyone in the family had therapy in the past? If so, who and when (year)?
______________________________________________________________________________________
______________________________________________________________________________________

Who in the immediate family has had a previous mental health diagnosis? (bipolar, depression, anxiety, schizophrenia, etc.) ____________________________________________________________________

Who in the family has substance abuse or alcohol problems? If anyone, have they been treated in the past (rehab, counseling?)
______________________________________________________________________________________

Does anyone in the family have current legal problems? Y or N

As a family or individually, do you practice a particular faith? If so, what faith do you practice?
______________________________________________________________________________________

How did you hear about Let It Rain Psychotherapy? (Google search, Psychology Today, a website, friend, family, psychiatrist, etc.)
______________________________________________________________________________________

**Let It Rain Psychotherapy, PLLC**
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Hello and welcome to Let It Rain Psychotherapy. I am very happy that you have decided to take the steps to better family relationships. After all, family relationships are the most significant relationships we have. In this document you are given the opportunity to learn about how I run my practice. Please know that any and all questions regarding receiving therapy here are considered good questions. Please feel free to ask questions regarding this consent or any other aspect of this practice.

It is important that you are aware that family therapy often brings out emotionally distressing thoughts and feelings that can be hard to endure. Sometimes individuals can become upset with pain, confusion, sadness/grief, fear or anger. This is the normal process of therapy that, when fully engaged in the process, everyone experiences. The hope is that as each family member commits to doing the hard work of personal growth and transformation, the distressing thoughts and feelings will lessen and relationships will improve. I use family systems theory, cognitive behavioral therapy, and other therapeutic modalities as appropriate that I believe will be of most benefit to families.

**Confidentiality**

It is my duty to protect your family's privacy. I will not disclose your record of psychotherapy to anyone without your written consent, nor will I tell anyone that you are my client. There are a few exceptions to this confidentiality agreement and they are:

- If I believe that one of you are in imminent danger of harming yourself or someone else, I must inform the proper authorities. That means I will call 911 and/or a mental health crisis team to meet you where you are to assess your needs and care for you. If I believe one of you are seriously planning to take your life or the life of another person, I must call 911 and alert the authorities of your plans and the nature of our therapeutic relationship.
- If one of you reports to me that a child, an elderly person, or disabled individual is being or was being abused, I must report to the Texas Department of Family Protective Services (CPS or APS). I am obligated by law to make a report of any information I receive about abuse to children, the elderly, and people with disabilities.
- If a judge subpoenas your record, I am obligated to comply. I will inform you if this happens.

My email raynejohnson@let-it-rain.org is NOT secure. It is a G Suite (Google) email account and although emails are encrypted, there is still a risk that email communications between therapist and client can be intercepted by others. Please do not email personal information you do not want the public to know. Secure electronic communication is only through therapyappointment.com if you are an existing client and I give you a password. You must request this password. **Please do not email me- I do not regularly check email.**

**Cost**

Accepted forms of payment are cash, credit or debit. You must allow a credit/debit card to remain on file to be a client here. Your initial 60 minute session in which you undergo a clinical assessment is $150. The assessment will help us both understand any clinical presentation (diagnoses) any family member may have and will direct our problem identification, goals and objectives, and then, later, the conclusion of our journey together. After the initial visit, the fee is $125 per 50 minute session for couples and $150 for families to be paid at the beginning or end of each session. Insurance accepted is limited to BCBSTX, Medicare and Medicaid at this time, however, if that changes active clients will be notified. *If, when I file your insurance, insurance refuses to pay for the session for any reason you are responsible for paying the fee the insurance company denied within the week of the insurance denial notice*. If you have a different insurance I do not accept at this time, at your request you are given a receipt to file for reimbursement on your own. Please see Services and Fees Form for additional information.

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**Emergency Contact**
I understand that emotional crises sometimes happen after hours. At this time, I am not able to be on-call 24 hours. If you have an emergency during the time I am not keeping office hours, after normal business hours, or if I am with other clients, you must call 911 or go to your nearest emergency room. Currently, when you call me and leave voicemail, I will respond within 12 hours. **Do not email me emergencies- I do not regularly check email.**

**Phone Calls**
Calls initiated by you between sessions that require psychotherapeutic consultation over 5 minutes will be prorated per 15 minute increments at the above costs: $25 for first 5-15 minutes, additional $25 for 16-30 minutes and so on to be paid at the time of the call.

**Court Appearance**
I do not make arrangements for court testimony. However, if you have me subpoenaed by a lawyer or judge, and I am forced to give testimony, the fee for this service is $250/hour with a 4 hour minimum and a $50 per day per diem. If travel is required, mileage charges will be added at the rate of $.50/mile. A fee of $25 for paper copies of progress notes to the judge is also charged to you. Minimum payment for this service is expected at least one week PRIOR to the scheduled court date. I do not give refunds or credits for court summons.

**Your Records**
After each session, I record brief notes related to what was discussed, insights, progress made, the therapeutic intervention, plans moving forward, etc. Unless I am subpoenaed by the court, this record will not be released without your written consent. If I am subpoenaed by the court, I will inform you and we will work together to be in compliance with the court. Please know that I will ask the judge to respect the therapist-client privilege, however I can make no guarantee that he/she will agree. You have the right to request in writing your records if you wish to see them. I will make a copy of them at a cost to you of $5 per page. We will then review them together so you understand what is written and the reason. If I believe certain parts of your record would cause you unnecessary emotional distress, I will respectfully give you straightforward reasons for why I wish to keep a portion of your records under lock and key. Rest assured that my feedback is honest and sincere. If you are unsure of my thoughts and feelings related to your progress, rather than ask for your records, please just ask me.

**Cancelations**
I respectfully request 24 hours advanced notice of your need to cancel a scheduled appointment. Notice of cancelation *less than 24 hours will result in your being charged for the full amount* of the missed session- $125 for couples and $150 for families. There is a $50 no show/late cancelation fee for initial sessions. There are exceptions: HEB-ISD closes school due to snowy or icy road conditions; you have an illness that requires hospitalization; death of an immediate family member; I am able to fill your appointment time slot with another client; you reschedule within the same week and attend that session. You *will not* be charged the cancelation fee within these exceptions.

Finally, it is important that as a family you make your appointments a priority, be willing to try new things, take personal responsibility for improving relationships and give me honest feedback. I will do everything I can to ensure you get the most out of your therapy sessions.

Please sign on the following page…

By signing below, you are indicating that you have read and understand this informed consent and agree to its terms.

Parent Signature ______________________________________________________________

Parent Signature ______________________________________________________________

If child is a minor age 11 or older and attending first session-

Child Signature: ______________________________________________________________

Child Signature: ______________________________________________________________

# Notice of Risk and Consent to Communicate Electronically

Communication between sessions is sometimes necessary. The most secure way to communicate so that your confidentiality is protected is by way of phone calls. Text messaging is the next most secure way of communication because my cell phone is password protected and the message goes directly to your phone. The least secure way of communicating with me is through email. My email is a regular email account which means it is no more secure than Google or Yahoo. The risk of destroyed privacy is high when using email. Email sent between you and I could be hacked, intercepted, and dispersed to others.

By signing below, you indicate that you have read, understand, and agree with the above notice of risk. By initialing by your preference(s), you indicate the method of contact for which you give permission.

My therapist has: (initial by preference(s))

_____/_____ Permission to call my cell.

_____/_____ Permission to leave voicemail.

_____/_____ Permission to respond to email from me.

_____/_____ Permission to contact me via text.

_____/_____ Permission to contact me via email through therapyappointment.com.

_____/_____ Do not contact me by any of the above means **except by *phone call.***

Signature: ______________________________________________ Date: _________________

Signature: ______________________________________________ Date: ________________

## ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically – through funds transfer or using a payment card -- using any of the following services:

- *Cayan or TSYS*

**Please Be Aware of the Following:**
**I** have a duty to uphold your confidentiality, and thus wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include this practice's name and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. I am unable to control this in many cases, and may not be able to control which email address or phone number your receipt is sent to.

So before using one of the above services to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?
- Is it better for me to pay cash to avoid these risks all together?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to *Let It Rain Psychotherapy PLLC.* Please consider who might have access to your statements before making payments by credit or debit card.

**I have read, understand, and agree with the above risks of paying electronically by using Cayan or TSYS and I know I have the option of paying by cash.**

**Parent Signature:______________________________________________ Date: ____________**

**Parent Signature:______________________________________________ Date: ____________**

## Notice of Insurance

Please be aware that when using insurance to pay for sessions, insurance companies sometimes request your psychotherapy progress notes. Information they collect includes times/dates of your session, length of session, symptoms, diagnosis and treatment plan, general discussion points, progress and plan going forward. This is standard procedure and is used, normally, for determining how many more sessions they will continue to pay. I am obligated to comply in the event of a request to view your file.

If you would rather not risk the chance of insurance requesting your therapy file, please refer to my private pay fees:

Individual Psychotherapy Initial Session (60 minutes): $150
Individual Psychotherapy Session (50 minutes) $100

Couples Counseling Initial Session (60 minutes) $150
Couples Counseling On-going Sessions (50 minutes) $125

Family Counseling Initial and On-going Sessions (60 minutes and 50 minutes) $150

**Choose one:** (parents present must initial by preference)

__ /__ (initial) I have been informed, understand, and agree **to continue** using insurance for my sessions.

__ /__(initial) I have been informed, understand, and **no longer wish** to use my insurance.

______________________________________________
Print Name Signature Date

______________________________________________
Print Name Signature Date

**Let It Rain Psychotherapy, PLLC**
**1901 Central Drive Ste. 716 Bedford Texas 76021**
**817-874-8169**

## Services and Fees Summary

**Therapy**
Individual Psychotherapy Initial Session (60 minutes): $150
Individual Psychotherapy On-going Sessions (50 minutes) $100
***(Only BCBS insurance accepted but I will help you access out of network insurance if you have a different insurance for reimbursement. If you have BCBS your co-pay is usually $0-$40)***

Couples Counseling Initial Session (60 minutes) $150
Couples Counseling On-going Sessions (50 minutes) $125
Family Counseling Initial and On-going Sessions (60 minutes and 50 minutes) $150

**Therapeutic phone calls between sessions** (Insurance does not cover phone calls)
Current clients $25 first 15 minutes paid at beginning of call. A longer call than first 15 minutes- $25 each 15 minute increment.
**Previous** clients or parent(s) of previous client: $35 first 15 minutes, $35 thereafter each 15 minute increment.

**Forms and Summaries**: (Insurance does not cover forms and summaries)
$45 per form current clients (seen within last two-three weeks)
$55 per form previous clients (not seen in last 3 months)

**Case Consultation in-office** (Insurance does not cover consultation services)
$65 for 30 minutes; $85 for any time after 30 minutes up to 50 minutes (current clients)
$85 for 30 minutes; $100 for 50 minutes (previous clients not seen in last 3 months)

For more detailed information on above services and fees, please ask therapist for official form.

Rayne Johnson, LCSW
Let It Rain Psychotherapy, PLLC
1901 Central Dr. Ste. 812 Bedford, TX 76021


**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 INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I will follow the privacy practices that are described in this Notice. If I amend this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practices, or for additional copies of this Notice, please let me know your questions as soon as they arise.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Without My Written Authorization. I may use and disclose your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

Treatment: I may use and disclose your PHI to other clinicians involved in your care in order to better provide integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.

Payment: I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

Health Care Operations: I may use and disclose your PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For, example, I may disclose disguised information about our work for training purposes.

Required or Permitted by Law: I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. In addition I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as authorized by law.

Permissible Uses and Disclosures That May Be Made Without My Authorization, But For Which You Have An Opportunity to Object.

Fundraising: I may use your PHI to contact you in an effort to offer you new services. I may also disclose PHI to any foundation with which I am connected so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

Family and Other Persons Involved in Your Care. I may use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) your personal representative, or another person responsible for your care, location, general condition, or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In

the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. I will also use my professional judgment and my experience to make reasonable inferences of your best interest in allowing another person access to your PHI regarding your treatment with me.

Disaster Relief Efforts. I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

# Let It Rain Psychotherapy, PLLC
# Rayné Johnson, LCSW
# Family Therapy Intake and Informed Consent

Rayne Johnson, LCSW
Let It Rain Psychotherapy, PLLC
1901 Central Dr. Ste. 812 Bedford, TX 76021

**NOTICE OF PRIVACY PRACTICES**

Uses and Disclosures Requiring Your Written Authorization.

Psychotherapy Notes. I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as permitted by law.

Marketing Communications; Sale of PHI. I must obtain your written authorization prior to using or disclosing your PHI for marketing or the sale of your PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing me with written notification of such revocation.

MY INDIVIDUAL RIGHTS

Right to Inspect and Copy. You may request access to your medical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Request Restrictions. You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to Rayne Johnson, LCSW. I am not required to agree to any such restriction you may request, except if your request is to restrict disclosing your PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and should explain why the information should be amended. I may deny your request under certain circumstances.

Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to Rayne Johnson, LCSW at any time.

Right to Receive Notification of a Breach. I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at 817-874-8169. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

Effective Date. This Notice is effective on September 2013.

Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office and on my website at www.let-it-rain.org. You may also obtain any revised notice by asking me directly.

**This is your copy. Please sign the following page.**

Rayne Johnson, LCSW
Let It Rain Psychotherapy, PLLC
1901 Central Dr. Ste. 812 Bedford, TX 76021
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of Rayne Johnson, LCSW's Notice of Privacy Practices.

Printed name ____________________________________________________________________________

Signature ___________________________________________________________Date____________________

Signature of LCSW _____________________________________________________ Date____________________

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ___________________________________________________________

Relationship to Client: ___________________________________________________________________

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign _____
- Communications barriers prohibited obtaining the acknowledgement _____
- An emergency situation prevented us from obtaining acknowledgement _____
- Other (Please Specify) ________________________________________

**This form will be retained in your medical record**