Sarah Billingsley, LMSW
Supervised by Rayné Ventimiglia, LCSW
Let It Rain Psychotherapy, PLLC

Initial Forms

Name:_____ Date of Birth:_____ Date:_____

Ethnicity: Check any/all that apply

_____Caucasian ____ Black/African American ___Hispanic/Latino ___Native American

_____Asian/Pacific Islander _____Other: _____

Address:_____

Phone Number:_____ Email:_____

How do you want to be contacted: (circle one) Phone Call Email Text

Can I leave a voicemail? (circle one) Yes No

Can I text message appointment reminders: (circle one) Yes No

How did you hear about *Let It Rain Psychotherapy*? (ex: Google, Psychology Today, Therapist, Friend/Family, etc.) _____

Individual Therapist: _____

Name Address Phone Number

Psychiatrist: _____

Name Address Phone Number

Would you like an emergency contact on file? If so:

_____

Name Address Phone Number

Relationship to Emergency Contact: _____

By giving emergency contact and signing below, I give permission to Sarah Billingsley, LMSW to contact person listed in the event of an emergency.

Signature:_____ Date: _____

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Main reasons for which you are seeking therapy:

1._____

2. _____

What do you hope to accomplish in Therapy?

1._____

2._____

Medications

Current prescribed medications:_____
Over-the-counter medications:_____
Past serious medical conditions: _____

Therapy History

Have you received therapy before? Y or N
If yes, please indicated whether you received (circle): In-patient Out-patient Both
What was the reason for previous treatment?_____
When and where treated?_____
How long was treatment and previous diagnosis:_____

Substance Use

Cigarettes (packs/day):_____Age/grade started: _____
Alcohol: age started/grade: _____ How much alcohol and how often?_____
Daily amount_____Weekly amount_____ Monthly amount_____
Drugs (please specify type(s)): _____
Usage: Daily amount: _____ How much money spent?_____
Weekly amount:_____ How much money spent?_____
Monthly amount:_____ How much money spent?_____

Family History

Please describe any mental health problems had by grandparents, parents, aunt, uncles, siblings, spouse, children such as depression, anxiety, bipolar, schizophrenia or any other mental health problem:

_____

_____

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Initial Forms

Informed Consent to Treatment

Welcome. I am glad you took courageous steps to find hope and change. Our time together is valuable for clarity, transformation, growth, and peace related to what is troubling you. There are some things you should know as we begin our journey together:

The Nature of Therapy

I use cognitive behavioral therapy in combination with other modalities of therapy I believe will maximize your time here. As you might imagine, therapy delves into thoughts and feelings that may be very distressing and cause emotional upset. This response is normal and necessary for healing and recovery. However, at any and all times you have the right to initiate a discussion of positive and negative effects of this therapy and I will work hard to ensure, to the best of my ability, your desired outcome.

Confidentiality

It is my duty to protect your 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 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 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 you tell me 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 abuses 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.
- It is also pertinent for you to know that I am a Licensed Master Social Worker under clinical supervision by Rayné Ventimiglia, LCSW as I work towards my clinical licensure. This means I am required to review all of my client cases with her to ensure you are receiving ethical treatment within my areas of competency. There will be times when Rayné Johnson, LCSW must review your records to ensure proper documentation and that I meet the standards of our profession as it relates to providing clinical care. Feel free to discuss any questions or concerns you may have regarding this information with me at any time.

My email sarah.m.billingsley1@gmail.com 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.** The safest form of contact is through call or text. My number is – 214-629-5245

Cost

Accepted forms of payment are cash, credit or debit. You must have a credit/debit card on file to be a client here. Your initial session includes an assessment can last up to an hour. The assessment will help us both understand

any clinical presentation (diagnoses) you have and will direct our problem identification, goals and objectives, and then, later, the conclusion of our journey together. The fee for sessions is $75 for individuals and $85 for families. Ongoing sessions are 50 minutes.

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. Please do not email emergencies.

Phone Calls
My phone number is 214-629-5245. I normally do not provide therapeutic telephone assistance between sessions. Always call 911 or go to your nearest ER if you feel unsafe. At the time you request a phone session I will use my professional judgment to determine if a phone session is appropriate or if it is best that you come into the office for the session. Rates for therapeutic phone calls between sessions are prorated per 15-minute increments at the above costs: $18.75 per 15 minutes to be paid at the beginning of the call. Additional time spent after the first 15 minutes will be charged at the end 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.

Your Records
After each session, I record brief notes related to what was discussed, insights, progress made, 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- $75 for individuals; $100 for couples and $125 for families; $50 if it was an initial appointment. There are exceptions: HEB-ISD closes school due to snowy or icy road conditions; 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.

Sarah Billingsley, LMSW
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Initial Forms

Informed Consent to Treatment Continued

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

Please sign final page…

By signing below, you are indicating that you have read, asked any questions you have, understand this document and agree to its terms.

Client Signature _____

Client Name (Print) _____ Date: _____

Therapist Signature _____ Date: _____

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Initial Forms

Teletherapy/Telemental Health Consent

I, _____, hereby consent to participate in telemental health with, _____ as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at817-874-8169 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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Initial Forms

Teletherapy/Telemental Health Consent Continued

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. Let It Rain Psychotherapy, PLLC-Sarah Billingsley Tele-therapy Informed Consent.

In case of an emergency, my location is: _____

_____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client_____Date_____

Signature of Parent if client is a minor_____ Date _____

Signature of Parent if client is a minor_____ Date_____

Signature of therapist_____ Date: _____

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Initial Forms

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:
We have a duty to uphold your confidentiality, and thus we 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 our business 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. We are unable to control this in many cases, and we 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/TSYS and I know I have the option of paying by cash.

Client or Parent/Guardian Signature:_____ Date:_____

Print Name:_____

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Initial Forms

Electronic Communication Consent

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. The least secure way of communicating with me is through email. My email is a regular email account through Google. 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, and 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:

_____ 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.

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

Signature:_____ Date:_____

Print Name:_____

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Initial Forms

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.

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Initial Forms

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 Sarah Billingsley, LMSW. 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 Rayné 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.

Sarah Billingsley, LMSW
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Let It Rain Psychotherapy, PLLC

Initial Forms

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of Sarah Billingsley, LMSW's Notice of Privacy Practices.

Printed name of client _____

Signature of client_____Date_____

Signature of LMSW _____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