Family Service of El Paso

6040 Surety Drive
El Paso, Texas 79905
Office: (915)781-9900
Fax: (915)781-9930

CLIENT INFORMATION

Welcome to Family Service of El Paso. Our office hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. Appointments on Saturdays are available on a limited basis. Our staff will be glad to assist you in anyway. At the same time, we ask for your cooperation with the following:

- Keep all scheduled appointments or give at least a 24-hour cancellation notice. **(Your regular fee will apply if 24 hour notice is not given.)**
- Make payments for your session at the time of service.
- Don't be later than 15 minutes to your appointment, this does not allow enough time to have a full session with you and you will likely not be seen.

We use a sliding fee scale to determine the amount per session based on your total monthly or annual income. The fee can be reduced or waived under certain circumstances. These conditions include having the cost of services paid through a grant or contract. United Way funds are used to operate the sliding fee scale. We also accept clients who are covered by Medicaid, Medicare (co-pay applies), CHIP (co-pay applies) and insurance (co-pay applies). If you are covered by insurance you will be assessed a fee based on a sliding fee scale or according to your mental health benefits. You are responsible for paying this fee at the time of your appointment.

Payment is due at the time of service. Clients who are three payments delinquent will **not** be allowed to schedule another session until payment arrangements have been made. Client records will not be released if client is not up to date on payments.

Records and confidentiality - The agency maintains a record of the services provided to you. Agency personnel that have access to your records include your therapist, your therapist's supervisor, and the contract compliance clerk. Accounting staff also has access to information necessary for billing purposes to better serve our clients. All agency employees adhere to strict codes of confidentiality.

The agency treats your records as a confidential document, but part or all of it may be shared outside the agency under the following circumstances:

- When you give consent in writing for the release of information.
- When the record is subpoenaed by a court.

- When alleged physical or sexual abuse, and/or neglect of a child is involved, (per Texas Statute).
- When there is danger of harm to yourself or others, (per Texas Statute)
- When funding sources which help pay for your service qualify for payment.
- If you were referred by an agency with legal authority to receive reports whether or not you keep your appointment and what progress you are making.
- If you are a minor and it is the judgment of the therapist that parents need certain information in order to carry out their duty as parents, or if keeping information from parents would interfere with your getting the help you need.

Client Rights

As a client, you have the following rights:

- You and your family have the right to appropriate treatment by qualified staff. You and your family have the right to know the qualifications and training of persons in charge of your treatment.
- You have the right to request another therapist and to be informed of any changes in staff involved in your treatment.
- You and your family have the right to a treatment plan to help you reach your goals in therapy.
- You may be asked to allow other staff members to observe your therapy sessions and/or to have your sessions videotaped. This will be done for the benefit of your therapy goals and for staff training. Such observation or taping can only be done with your written permission. You can withdraw this permission at any time.
- You have the right to see your records for the purpose of ensuring their accuracy.
- You have the right to request the presence of a third party at your therapy sessions.
- To receive services for a child, the parent or person requesting services needs to have legal custody of the child. Be aware that parents with possessory, conservatorship (visitation rights) also have a right to see the child's record.

Family Service of El Paso has the right to be treated courteously by you. The following activities may result in discontinuation of service:

- Violent behavior
- Threats to or harassment of staff
- Being at our facility under the influence of mood altering substances which may render a client irrational or offensive to others.
- Overt sexual acts or threats to staff or other clients.

Privacy of Others

Clients are expected to maintain privacy while in the lobby area.

- Do not discuss personal confidential information with others in the lobby area.
- Do not ask others in the lobby personal confidential information.

Grievance Process:

It is Family Service of El Paso's goal to provide the highest quality service. Agency staff will be glad to discuss with you any questions or concerns you may have. If, in our working together, a

problem arises, agency staff wants to resolve the issue in a timely manner. The agency shall initiate an investigation of written complaints received **within two business days**. Clients with special needs who request or need assistance to put their complaint into writing shall be provided with assistance by an agency staff person.

Individuals receiving Ryan White services have the right to complain directly to the Administrative Agency or to the State DSHS HIV/STD Program.

Administrative Agency
P.O. Box 2828
Lubbock, TX 79408-2828
1-800-658-6198 x624 (English) or x308 (bilingual)

DSHS HIV/STD Program
P.O. Box 149347 MC 1873
Austin, TX 78714
1-512-533-3000

NO SHOW AND CANCELLATION POLICY

Family Service of El Paso has set the following policy regarding no shows and cancellations. This policy is necessary due to the agency's limited resources and the need for services from the community exceeding the agency's ability to meet such need.

FAILURES:

A failure is defined as a client not showing up for his or her session without any notification to the agency:

- If an ongoing client has two failures his or her case will be closed.
- Clients who have not contacted the agency for one month will have their case closed.

CANCELLATIONS:

- Clients with three consecutive cancellations will not be rescheduled.
- Clients who cancel more than they attend sessions will be terminated.
- Clients unable to keep a scheduled appointment, please notify our office or leave a message on the Agency's answering machine at least 24 hours before your appointment time. Your scheduled time is reserved for you alone and, if not used by you, may prove to be a loss for someone else wishing to use that time. **Thus, you will be charged the full fee for cancellations made with less than 24 hour notice**. Unforeseen emergency situations will be taken into consideration**.** Please be aware that we cannot bill your insurance company for failed appointments or appointments cancelled without 24-hour notice. In these situations, you will be responsible for your entire fee.

REMINDERS:

- As a courtesy, our staff makes reminder phone calls at least one evening before your appointment. It is **your** responsibility to remember your appointments.
- It helps us schedule other clients for appointments if you notify us when you will not be attending your session.
- If you are more than 15 minutes late you will likely not be seen and will be charged for a missed appointment.
- Please keep us advised of your address and/or phone number changes.

Legal Consultation Fees

If you become involved in litigation which requires the participation of your therapist, you will be expected to pay a fee of $100.00 per hour (two hour minimum) for professional time required even if your therapist is compelled to testify by another party. Because of the complexity and difficulty of legal involvement, per hour charge for preparation and attendance at any legal proceeding may be higher than your therapist's usual clinical fee.

If your circumstances require that your therapist travel away from the office to provide professional services, the hourly fee will include travel time and a mileage fee will also be assessed.

Family Service of El Paso
Registration Information

Client Contact Information

Print Client Name:

Address:_____

_____

Contact Phone:

Email _____

Communication method preferred to confirm your appointment one day before?
◉Email ○Telephone ○No Reminder

By providing my email address I hereby authorize Family Service of El Paso to communicate with me electronically.

Emergency Contact:
Name: **Ph.**

Signature_____

Personal Information

SSN:

Date of Birth

Male ○
Female ○

Highest Level Education:

Language Preference: **English** ○ **Spanish** ○ **Other:**
Who has the right to schedule or cancel appointments for the client?

Race: ***Check All***
[ ] Y [ ] N White
[ ] Y [ ] N Black or African American
[ ] Y [ ] N Asian
[ ] Y [ ] N Native Hawaiian/Pac. Islander
[ ] Y [ ] N American Indian/Alaska Native
[ ] Y [ ] N other _____
[ ] Y [ ] N unknown

Hispanic group: ***Check Only One***
○ Mexican/Mexican American
○ Cuban
○ Puerto Rican
○ Central American
○ South America
○ Spanish, Potuguese, C. Verdean
○ Other Caribbean
○ Other Hispanic_____
○ Not Hispanic

Spouse/Partner/Guardian Information

Marital Status:

Single ○ **Married** ○ **Separated** ○
Divorced ○ **Widow(er)** ○ **Living Together** ○

Name:

SSN:

Highest Level Education: | **Date of Birth** | **Male [ ] Female [ ]**

Race: ***Check All***
[ ] Y [ ] N White
[ ] Y [ ] N Black or African American
[ ] Y [ ] N Asian
[ ] Y [ ] N Native Hawaiian/Pac. Islander
[ ] Y [ ] N American Indian/Alaska Native
[ ] Y [ ] N other _____
[ ] Y [ ] N unknown

Hispanic group: ***Check Only One***
[ ] Mexican/Mexican American
[ ] Cuban
[ ] Puerto Rican
[ ] Central American
[ ] South America
[ ] Spanish, Potuguese, C. Verdean
[ ] Other Caribbean
[ ] Other Hispanic_____
[ ] Not Hispanic

Language Preference: **English** ○ **Spanish** ○ **Other:**

Children Information

Name	Sex	DOB	SSN

Number of Family Members:

Referral Type

Friend ◯ **Phone Book** ◯ **Hospital** ◯ **Former Client** ◯ **School** ◯
Relative ◯ **Insurance** ◯ **Law Enforcement** ◯ **Doctor** ◯ **Internet** ◯
Brochure ◯ **Social Service Agency**:_____

Type of Problem

Standard

Check appropriate response

[ ] Depression	**[ ] Marital Problems**	**[ ] Anxiety**
[ ] Child Sexual Abuse	**[ ] Child Physical Abuse**	**[ ] Domestic Violence**
[ ] Child Behavior Problem	**[ ] Parent/Child Conflict**	**[ ] Stress**
[ ] Divorce/Separation Issues	**[ ] Crime Victims**	**[ ] Other**

Financial Information

Employment:

Head of Household	Spouse/Partner/Guardian
Employer:	**Employer:**
Job Title:	**Job Title:**
Insurance/Medicaid: Yes ◯ No ◯ **Company Name:_____** **Policy/Group #:_____**	**Insurance/Medicaid: Yes ◯ No ◯** **Company Name:_____** **Policy/Group #:_____**

Does anyone else who will receive services have Medicaid Coverage? Yes ◯ No ◯

Fee is based on 1/10th of 1% of the ANNUAL gross household income with the minimum payment being $10.00 and the maximum payment being $100 per session.

Gross Household Annual Income:$_____ = Fee per session $_____

Our standard rates are $100 for one hour of individual or family therapy. We recognize that therapy requires a significant investment, both emotionally and financially. Due to the high cost of billing, we require payment for services at the time they are delivered. By signing below you agree to pay all sessions at the assessed rate and also for any missed appointment not cancelled with a 24 hour notice. (Arriving more than 15 minutes late will be considered as a missed appointment and fee will apply.)

Income verified by: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

Comments:_____
_____
_____

Therapeutic Agreement

Have you been in counseling/therapy before? **Yes** ○ **No** ○

(If yes) Name of Therapist:_____ **Agency:**_____

Dates: _____

Are you presently taking any medications? **Yes** ○ **No** ○

(If yes) Name of Medications:_____

Name of Physician/psychiatirist:_____

Because I/We, _____ understand that individual, group and family counseling are
(Name of client/legal guardian)
not exact sciences, I do not hold the staff and board of Family Service of El Paso in any way responsible for the outcome of my/our treatment.

I accept full responsibility for the value received and the outcome obtained from my/our therapeutic contract with the agency.

I have been informed and do understand the issues of confidentiality, fee schedules/payment, the limits and guidelines of services provided and my responsibilities as a client.

I/We _____ agree to enter into a course of treatment for _____with
(Name of client/legal guardian) *(Name of client being treated)*
Family Service of El Paso hereby giving consent for treatment.

I have received and thoroughly read the Client Information as stated by Family Service of El Paso.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Witness Signature (Staff) Date

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CLIENT INFORMATION

I agree to keep all scheduled appointments or give at least a 24-hour cancellation notice. I understand that my regular fee will apply if 24 hour notice is not given, or if I arrive more than 15 minutes late.
I agree to make payments for my session at the time of service
I understand that payment is due at the time of service and I agree to make payments for my session at the time of service
I understand that if I am three payments delinquent I will **not** be allowed to schedule another session until payment arrangements have been made.
I understand that as a courtesy, the staff makes reminder phone calls at least one evening before your appointment; it is **my** responsibility to remember my appointments.

I have read the client information forms and understand my rights as a client of Family Service of El Paso.

Client Name:_____ Date:_____

Client/Guardian Signature:_____