Margaret Baier, Ph.D., LMFT
Baier Equine Assisted Retreat, LLC
Licensed Marriage and Family Therapist
1000 Sommerfeld Drive, Waco, Texas 76705
400 Austin Avenue, Suite 300, Waco, Texas 76701

Patient Information and Consent Forms

Name of Client #1____ Date______________

Address____City__________________Zip Code____________

Cell Phone _____________________________________

Email____

Date of Birth __________ Age ________Marital Status ____________

Name of Client # 2 ____ Date______________

Address____City__________________Zip Code____________

Cell Phone _____________________________________

Email____

Date of Birth __________ Age ________Marital Status ____________

If you wish to receive a "Paid Invoice" that you may use to submit to your insurance company to request reimbursement, please indicate below where you wish the invoice to be sent.

Send Invoice to: ☐ email ____

☐ USPS address ____

☐ DO NOT SEND INVOICE

In case of emergency notify _________________________ relationship _____________ Phone _____________

Therapist Disclosures & Informed Consent

Duty to warn: State law requires that a therapist must inform child protective services if child abuse is suspected or revealed. Therefore, any information regarding this issue will be reported to the Child Protective Service Agency. I will also inform an individual and/or the proper authorities when a life-threatening accusation is made toward oneself or about another individual.

Confidentiality: Therapists are bound by their code of ethics to keep all information shared in the therapy session confidential. This rule can be broken only if the duty to warn is enforced by the therapist. Minor children's right to confidentiality will be discussed both with the parents of the child(ren) and the child(ren). Decisions regarding child confidentiality will be made on a patient-by- patient basis. Please discuss this matter thoroughly with the therapist.

Records: This practice is HIPPA compliant and patient records are protected. The therapist will retain patient records for 7 years following termination of treatment. After 7 years, the records will be destroyed unless there have been further transactions, therapy, or claims between the patient and therapist. As movement is made toward becoming "paperless", all electronic records will be protected and will not be transmitted electronically unless encryption is available. Be advised: The records that belong to the patient include the intake form and accompanying documents and billing records which may include diagnoses and treatment procedures. The records that belong to the therapist and may not be shared with the patient include any notes made by the therapist for the purpose of facilitating treatment. Release of records must be accompanied by a signed Release of Information that specifies to whom information should be released, for what purpose this information will be released, and the duration of the authorization.

Conduct of Therapy: The therapist shall adhere to the code of ethics of the American Association of Marriage and Family Therapy in addition to other professional counseling organizations (whichever is most stringent) and to the laws of Texas as they pertain to patient-therapist relationships.

Complaints should be address to: The Texas State Board of Examiners of Marriage & Family Therapists, 1100 W. 49th Street, Austin, Texas 78756

I have read and understand the therapist disclosures and the limitations of confidentiality.

Patient #1 signature ____ Date _______________

Patient #2 signature ____ Date _______________

Patient #4 signature ____ Date _______________

Patient #5 signature ____ Date _______________

Therapist signature ____ Date _______________

Patient-Therapist Agreement

Fee Rate: The basic fee for therapy is $150.00 for 50 minutes. Longer or shorter sessions are prorated from this basic fee.

Psychological testing is not part of this practice. Patients will be referred to the appropriate person(s) for any necessary testing. If you desire official documents regarding treatment, these will be provided at the rate of $300.00 each to cover the time required to prepare these documents and will not be released until you have made full payment for this service.

Fees for court appearance, requested by you, your attorney, or through a subpoena, are $300.00 per hour. You will be responsible for all my time, including time for driving to court, waiting to testify, giving testimony, as well as preparation and/or research time that is required. Because it is necessary for me to block off my schedule for a full day to appear in court, you will be charged for a minimum of eight hours for each day in court. Payment for this eight-hour minimum is required at least one week prior to the court hearing.

Phone Consultation: The standard prorated fee will be charged for telephone time.

Payment Method: Payment is required at the time services are rendered. Payment may be made by check or cash, credit card, or Venmo.

Insurance and Third-Party Payments: Payment is expected at time of service. You may be supplied with a "Paid" Invoice which will include necessary billing codes so that you may file a claim with your insurance company. Insurance/ManagedCare/EAP/HMO/Medicaid clients: Behavioral/Mental Health coverage is often based on a reimbursement schedule that differs from medical coverage. Additionally, most managed care/EAP/HMO companies providing insurance coverage have limits to the dollar amount and/or number of visits they will reimburse. You will be responsible for any charges incurred beyond those benefits.

Missed Appointments: If you are unable to keep an appointment, please notify me immediately. If an appointment is cancelled or missed without 24 hours' prior notice, you may be billed for the session. Additional appointments may not be made until payment for the missed session is tendered.

By signing this agreement, the patient agrees s/he has read it carefully and has received a copy of both the fee agreement and the page titled "Therapist Disclosures & Informed Consent." The patient agrees to bring all questions or concerns that may arise regarding these fee policies.

Patient's signature (or responsible party) _________________________________ Date_______

Patient's signature (or responsible party) _________________________________ Date_______

Client Email/Texting Informed Consent Form

1. **Risk of using email/texting**: The transmission of client information by email and/or texting has several risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks: a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. B. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient. C. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy. D. Employers and on-line services have a right to inspect emails sent through their company systems. E. Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection. F. Email and texts can be used as evidence in court. G. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts:** Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions: a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period. B. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations. C. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well. D. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law. E. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information. F. Provider is not liable for breaches of confidentiality caused by the client or any third party. G. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. **Client Acknowledgement and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text.

Client #1 name: ____

Client #1 signature: ____ Date: _____________

Client #2 name: ____

Client #2 signature: ____ Date: _____________

Parent/Legal Guardian name: ____

Parent/Legal Guardian signature: ____________________________________ Date: _____________

Provider name: ____

Provider signature: ____ Date: _____________

Telehealth Consent Form

I understand that my therapist Dr. Margaret Baier provides telehealth services for mental and behavioral health. This means that I will be able to participate in therapy sessions with Dr. Baier through interactive video connection.

I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.

2. The video picture or information transmitted may not be of high quality.

3. I understand that I alone can control who is physically present with me during my telehealth therapy sessions with Dr. Baier.

The benefit of a telehealth therapy session is that I do not need to travel to the therapy session. This allows me to save time and money as well as prevent my potential exposure to pathogens.

I give my consent to participate in the telehealth therapy session with Dr. Margaret Baier. I understand that no other individuals will be present in Dr. Baier's office without my express written consent. I understand that confidentiality is forfeited if I indicate that I am a danger to myself or others, including a child, an elderly person, or someone who is disabled. I understand that confidentiality is also forfeited if Dr. Baier suspects that there is past or present abuse of a child, elderly person, or someone who is disabled. I understand that Dr. Baier will not share videotapes, digital recording films and photographs in the absence of such a danger.

I understand that Dr. Baier cannot control what I do with videotapes, digital recording films and photographs that I may generate during our therapy sessions. I hereby release Dr. Margaret Baier from all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I understand that I have the right to ask Dr. Baier to discontinue the therapy session at any time.

I have read this document and understand the risk and benefits of telehealth therapy services and have had my questions explained and I hereby consent to participate in telehealth therapy sessions under the conditions described in this document.

Client #1 name: ____

Client #1 signature: ____ Date:____________

Client #2 name: ____

Client #2 signature: ____ Date:____________

Request & Consent for the Release of Confidential Information

DO NOT complete this form unless you want your information released to a third party.

I authorize ____ to release information regarding

☐ my

☐ my child's

medical/psychological history to:

Margaret Baier, Ph.D. LMFT
Licensed Marriage & Family Therapist
Records & Billing Office
1000 Sommerfeld Drive
Waco, Texas 76705

I hereby give my consent for any and all of the requested information to be released

☐ one time only ☐ ongoing as need to facilitate treatment.

Signature of Client or Authorized person _________________________ date ______________

Authorization to Release Information

I authorize Dr. Margaret Baier to release information regarding my treatment in therapy to the following person(s), medical facility, or school:

Name ______________________________Organization_______________________________

Address ____Phone_____________________

I hereby give my consent for any and all of the requested information to be released

___ one time only ___ ongoing as need to facilitate treatment.

Signature of Client or Authorized person ___________________________date ____________