Lisa Binz Mongoven, Psy.D.
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Thank you for choosing me for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with my professional services and business practices, I would like to share the following information:

Appointments and Rates: Appointments are made either by phone or at the end of a therapy session. Therapy sessions are generally 50-60 minutes in length and cost $130. Intake sessions typically run longer and are therefore billed at a higher rate of $150. The number and frequency of sessions needed depends on many factors and will be discussed at our initial meeting. If you need to cancel an appointment, a minimum of 24 hour notice is required to avoid the $50 missed appointment charge. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In some cases, a phone appointment is a good alternative to canceling altogether. If the above fees become a hardship for you, please let me know so we can discuss options. Also, please note that court related costs are billed at $200 per hour. This includes any court cost, time needed for document preparation, depositions, time spent testifying or waiting to testify, and time spent driving to and from the court. A copy of your medical records may be obtained for a fee of $75. There is no reduced rate for court related costs.

Phone Calls: Due to my work schedule, I am not immediately available by phone most of the time. When I an unavailable, clients may leave messages on my private voicemail. I make an effort to return calls in a timely manner, usually within 24 hours. In the case of a psychiatric emergency, please contact your family physician, call 911, or go to the nearest emergency room and ask for the psychiatrist on call.

Financial Responsibility: You are fully responsible for all services rendered. Full payment is expected at the time of service unless other arrangements have been made in advance. Payment options include cash or check. There will be a $25 charge for checks returned as insufficient funds. If an account becomes significantly past due, correspondence regarding the past due portion of the account will be addressed by a mailed statement or by a phone call using the information given on the Patient Information Sheet. When fees are not paid in a timely manner, a collection agency may be given billing and financial information but no clinical information will be shared.

Requesting Third Party Payments: At this time, I am not accepting insurance payments. However, if interested, I would be happy to provide you with a receipt so that you may file for reimbursement using out-of-network benefits. You should be aware that once contacted, your health insurance company may require that I provide them with information relevant to the services that I am providing. I am generally required to provide a clinical diagnosis. Sometimes, I am also required to provide additional clinical information such as treatment plans, summaries, or even copies of your entire clinical record. In such situations, I will make every effort to release only the minimum amount of information necessary. Contact your insurance carrier if you have questions regarding how they handle your personal health information once it is received.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). The law protects the privacy of communications between a patient and a psychologist. Everything about your care will be held in the strictest confidence. In most situations, I can only release information about your treatment to others with your written permission. Possible exceptions to confidentiality include but are not limited to the following situations: 1.) When I have reason to believe that a person is in danger of hurting himself or someone else, 2.) When someone tells me about abuse of a child, a handicapped person or an elderly person, and 3.) When a mental health professional has been sexually inappropriate with his/her client. I may also be required to hand confidential information over to the court if subpoenaed to do so. If you have questions or concerns about confidentiality, it is important that you bring them to my attention so that we can discuss them further. Please note that parents or legal guardians of non-emancipated minor clients have the right to access their child's records.

Outside Relationships: It is important that you know that your relationship with me will be a professional and therapeutic one. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Outside relationships (either personal or professional) can undermine the effectiveness of the therapeutic relationship and are not permissible by the Texas State Board of Examiners of Psychologists.

Treatment Approach and Informed Consent: Counseling is a personal exploration and may lead to major changes in your understanding of yourself and the world. The information shared in sessions and the work done outside of sessions deeply affect success. Therapy has the potential to provide many benefits, but there are always risks associated with growth and change. Personal changes can affect significant relationships or even how one functions on his/her job. Informed consent means that you willingly enter into this therapeutic relationship knowing these risks exist. If you have concerns about the kind of risks you might be taking, it is important to share your concerns. Therapy may be discontinued at any time. I do, however, request that you notify me of your intentions and participate in at least one termination session if possible.

Consent for Treatment

Please sign below indicating that you have read and understood the above information and that you are consenting to receive psychological services from Lisa Binz Mongoven, Psy. D.

_____
Patient / Guardian Name (Print)

_____ _____
Patient / Guardian Signature Date

Child and Adolescent Consent for Treatment

Child's Full Name:_____ DOB:_____

I certify that I am the ☐ father ☐ mother ☐ managing conservator ☐ legal guardian of the above named child/adolescent and that I have legal custody of him/her. I, hereby, give my authorization and consent for the above named individual to receive psychological services from Lisa Binz Mongoven, Psy. D. I further certify that I have the legal authority to give such consent.

_____
Patient / Guardian Name (Print)

_____ _____
Patient / Guardian Signature Date