FOR NEW PATIENTS OF MARK THOMPSON, M.Ed., LPC-S ONLY.

Mark Thompson, M.Ed, LPC
3560 Delaware/ Suite 1205/ Beaumont, Texas/ 77706
(409) 729-0400

Practice Policy

Welcome. We have prepared this Practice Policy sheet in order to answer questions frequently asked by clients regarding fees, confidentiality, and services. Please feel free to talk with Mr. Thompson or his Office staff about any questions you might have. We will make every effort to develop a professional relationship that will be satisfactory to everyone.

FEES: The fee is $110 for a 45 to 50 minute session.

PAYMENT POLICY: It is customary to pay professional fees at the time of services. However, if you have insurance that pays a portion of the fees, please pay for the first session and then pay the percentage of fees that your insurance does not pay (Deductible and Co-payment). *Fees for services provided to children of divorced parents will be charged to the parent requesting and arranging the services. We do not do third-party billing.

APPOINTMENTS & CONFIRMATIONS: When an appointment is scheduled, that time is reserved for you and you alone. Each time a patient misses an appointment, another patient is prevented from receiving care and the office loses income which is needed to keep my practice viable.
As a courtesy, reminder text messages are sent out one day prior to your scheduled appointment. Mr. Thompson appreciates your prompt response to the reminder texts which enables us to keep the appointments and schedule running smoothly.

****CANCELLATIONS** : If you are unable to keep your scheduled appointment, we ask that you please cancel within 24 hours. A fee of $50 will be assessed to persons who "No Show" their appointment or give less than 24 hour notice of cancellation.**
Insurance companies will not reimburse this charge.
Future appointments will not be rescheduled until the fee is paid.

INSURANCE PROCEDURES: Your health insurance may provide reimbursement for psychological services. If you are unsure of coverage, we can obtain verification from your insurance carrier. Please consult with our office manager concerning verification of coverage. As a service, we will file your insurance claims for you, which we do daily. Your insurance information is customarily obtained when an appointment is scheduled. You will need to assign benefits to us as the provider, which allows the insurance carrier to reimburse us directly. Please be aware that, when filing for insurance reimbursement, you are required by the insurance carrier to authorize release of information to them concerning diagnosis and services provided. If you are concerned about confidentiality in the context of third party payment, please consult with your Insurance carrier and/or raise the issue for discussion with Mr. Thompson.

CONFIDENTIALITY: Texas law provides strict protection for clients seeking psychological services: all information regarding services is controlled by the client and is not to be released to anyone without the clients' written authorization.

There are, however, two exceptions in which therapists may be required to breach the rule of confidentiality. First, when in an emergency there is imminent danger to the client or other person(s), the therapist must act so as to protect the lives of those involved and may breach confidentiality to assure such protection. Second, in cases of child abuse, or elder, therapists are required to act so as to protect the children or elder from ongoing abuse and must breach confidentiality, if necessary, to do so.

PROFESSIONAL SERVICES: Mr. Thompson has office hours by appointment Monday - Thursday. He does **not** see patients on Fridays or on the weekends.
The office staff is regularly available on Tuesdays and Wednesdays from 9:00 a.m. to 4:00 p.m.and 9:00am to 1:00pm on Thursdays. **To schedule any and all appointments or for inquiries regarding charges, account balances, insurance filing, etc. are handled by the Office Manager. Please call Paula at (409)729-0400, ext. 105.**
Mr. Thompson is available by cell phone for emergency after hours coverage. That number is (409) 504-5650. There is no charge for brief telephone consultation, but it is expected that calls to Mr. Thompson's cell phone will only be made for emergency matters.

Your Informed Consent to Care : We have provided this information to you in hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, we invite you to discuss your treatment plan with Mr. Thompson. Moreover, your treatment plan will be specifically tailored to your individual needs and we urge you to actively discuss your treatment plan with Mr. Thompson so that you have a sense of direction regarding the care you are receiving. We are always open to discussing these matters with you. Please feel free to discuss any of these matters with us in more detail. By signing below, you acknowledge having read, understood, and agree to these policies and procedures.

Your signature acknowledges your informed consent to treatment and your acceptance of Mark Thompson's Practice Policies.

_____ _____

Signature of Client or Guardian Date

Mark Thompson, M.Ed, LPC
Licensed Professional Counselor

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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Healthy Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their healthy care records. You may have already received similar notices, such as this one, from your other care providers.

As you might expect, the HIPAA law and regulations are extremely detailed to grasp if you don't have formal legal training. My patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple, yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find I will do all I can to protect the privacy of your mental healthy records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Mark Thompson, M.Ed, LPC
Licensed Professional Counselor

I, _____understand and have been provided a copy of Mr. Thompsons Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected healthy information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature or Parent (if minor) or Legal Charge Date

If Legal Charge, describe representative authority_____

Mark Thompson, M.Ed., LPC

Patient Demographic Information

Please complete the following: **Today's Date:** _____

Last Name: _____ **First Name:** _____ **M.I.:** _____

Date of Birth: _____/_____/_____ **Male / Female Soc. Sec. #:** _____/_____/_____

Marital Status: ____Single ____Married ____Separated ____Divorced ___Widow/Widower

Employment Status: _____Full-Time _____Part-Time _____Not-Employed _____ Student

Race: _____ **Profession:** _____

Home Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Work: _____ **Email Address:** _____

Do you have a communication preference? _____ Cell _____Home _____Work _____Email

Employment or School Information -

Employer/ School: _____ **Employer/ School Phone:** _____

Address: _____ **Suite#:** _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact -

Contact Name: _____ **Relationship to Patient:** _____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _(_____)_____ **Cell Phone:** (_____)_____

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MEDICAL INFORMATION:

Do you have any medical problems? Please Explain_____

_____

Do you take regular medications? If so, what?

Name of Medication	Prescribed by	Dose

Have you seen a psychiatrist, psychologist or counselor before or been in a psychiatric hospital? If so, please list:

Type of Mental Health Service	Date	Provider

Are alcohol or drugs a problem for you?_____ If yes, please explain:_____

_____

Current or expected legal involvement? _____ Yes _____No If yes, please explain:

_____

_____

Briefly describe the problems or concerns that bring you here? _____

_____

_____

What would you like to accomplish by coming here (goals)? _____

_____

_____

Payment Information

Have you pre-authorized these visits through your insurance company? Yes No

If yes, authorization number:_____

If no, please check one of the following:

☐ I will pay my bill for services in full service at each visit.

☐ I have checked with my insurance and no pre-authorization is required. I am aware of my co-payment amount and will pay my copay amount in full at each visit.

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AUTHORIZATION TO RELEASE RECORDS and INFORMATION

Patient Name: _____ D.O.B. _____

I AM RELEASING MY HEALTH *INFORMATION FROM*: (e.g. - Name of Physician, Other Therapist)
(Please enter the entity you are requesting your health information from)

Name: _____

Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

I AUTHORIZE THE ABOVE NAMED ENTITY AND/OR HIS/HER ADMINISTRATIVE AND CLINICAL STAFF TO RELEASE:
(Provide description of the information you want disclosed. Please be as specific as possible.)

_____

I AUTHORIZE VERBAL COMMUNICATION BETWEEN MARK THOMPSON, LPC AND _____

I AUTHORIZE THAT MY PROTECTED HEALTH INFORMATION ONLY *BE RELEASED TO*:
(Please enter below who this information is being sent to)

Name: _____

Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Please release the patient's health records from: _____ to _____

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate. You have the right to revoke this authorization, at any time by sending such written notification to our office address. I understand that a fee may be charged for the costs of copying, mailing, preparing a summary or other supplies associated with my request. You will receive a response within 30 days of the receipt of your request if the records are requested from this office.

Signature of Patient: _____ Date: _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided:

Patient Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____