Anne Schanz, PhD, LPC
2828 E Trinity Mills, Suite 106
Carrollton, TX 75006

Office: 972-774-0221
Cell: 972-822-5901
Fax: 866-521-3652

CLIENT INFORMATION AND CONSENT FORM -Minors
General Information

Mental Health Services

While it may not have been easy to seek help from a mental health professional, please know that we are here to assist you to enhance your understanding of yourself, your situation and feelings. It is only through this increased understanding that you will move toward resolving the difficulties that have led you to seek professional assistance today. Your therapist, using extensive knowledge and experience of human development and behavior, will make observations about your situation(s) and offer suggestions for new ways to approach them. While we can offer many possible alternatives, it is always your responsibility to decide what is best for you. For the best results, you will be honestly exploring your own feelings and thoughts, as you try out new approaches to your problems. The most effective changes will be in your perspective, or how you see the problems you are experiencing.

Risks of Therapy

Therapy is the Greek word for change. We can predict that you and your relationships will change, but we cannot predict exactly what those changes will be. As you explore your alternatives and confront your feelings, assumptions and perspectives, you will change. Since even 'good' change is stressful there will be times when you are likely to feel strong emotions like anxiety, grief, anger and/or sorrow. As your change continues, the way you interact with friends and family will also change so your relationships will be different. At first, friends and family may not like the changes they see in you and they may be angry, sad or resistant. Your children are likely to test any new limits you set for them. Some people find they no longer fit well with some of their current friends or even in their marriage. Others experience an increase in intimacy and joy in these relationships from the beginning of the process. Because of all this, it is possible life will become more stressful before it is improved. Despite the risks, knowing yourself and what you need to be happy will ultimately allow you to have closer, more genuine relationships. Research indicates good relationships are the most important factor in personal happiness.

Confidentiality

Confidentiality is defined as keeping the information you share with your therapist private. We believe you have a right to privacy and that your therapy results depend on your trust and ability to share your thoughts and feelings safely. The staff and therapists in this office will do all we can to protect your privacy. We will only release information with your written consent except in the situations listed below in which we cannot control the privacy of your information.

Legal Confidentiality Limitations in Texas

In general, it is assumed you have a right to privacy. These are specific legal exceptions.

1. If your records are subpoenaed by a court, we are not legally empowered to deny the subpoena. We will have to provide your records.
2. We are legally compelled to notify authorities if you are, or are involved in:
    a. A danger to yourself or others.
    b. On-going child or elder abuse.
    c. Abuse of patients in care facilities.
    d. Sexual exploitation.
3. Court proceedings to collect fees
4. Licensing Board investigations.
5. HIPPA investigations.

Insurance Filing Issues

In order to file your insurance for reimbursement, managed care companies require us to provide information about your sessions.

1. This always includes date, type and length of service, and diagnosis.
2. Many companies require more specific details about your case to authorize services.
3. Some companies require detailed case reviews with their personnel before they will authorize additional sessions.
4. Some large companies are self-insured which means that they pay the medical claims themselves. As a result, they have access to *all the insurance and managed care records*. They are legally bound not use this information inappropriately, but they do have it. Please discuss any concerns you have with your therapist.

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Use of Digital Technologies

Warning: Be aware that if you use Digital Technologies to communicate with your therapist, there is an increased risk that your information privacy can be compromised. We are not technology experts, so we must rely on the expertise and validity of the claims from the companies we contract to provide secure digital communications. We will make every effort to find and use the simplest and most reputable services. Please indicate you accept this risk if you use any of the following technologies by initialing here_____.

1. Text messaging: Regular text messaging will be used only for appointment setting and logistics. Any messaging of personal information will only be conducted through a secure and encrypted platform as provided by your therapist.
2. E-mail communications: All E-mails will be sent through secure channels as provided by your therapist.
3. Video Sessions: Video sessions may be available to accommodate restrictions which prevent in-person sessions. These sessions will only be held on secured and encrypted platforms to protect privacy as determined by your therapist and as technological improvements develop. For any video session the client must have a quiet, private space for the duration of the session.

Please discuss any concerns you have at the beginning of your first session. We have no control over your information once it leaves our offices.

The Therapy Process and Procedures

Therapy Plan

You and your adolescent will be creating a therapy plan with the therapist in order to maximize results. First, the therapist will assist in establishing your goals. The therapy plan will be designed to accomplish your goals as quickly as possible. Your plan may include the number and frequency of sessions, types of sessions (individual, family, couples, or group) and the scope of the process. As a team, you, your adolescent and the therapist will decide what is reasonable and practical for your circumstances. The practical considerations will include all aspects of your unique situation and resources.

Therapeutic Relationship

Your relationship with your therapist is a professional and therapeutic one. The relationship itself is one of the most important reasons for change in therapy. To preserve it, certain limitations must be imposed. Your therapist cannot have a personal and/or business relationship with you. Dual relationships have been shown to undermine the effectiveness of therapy so we must restrict our contact to therapy appointments and issues only. If you have feelings about these restrictions, we urge you to address them with your therapist in session because addressing those feeling often leads to great therapeutic change.

Confidentiality issues in adolescent therapy.

Since adolescents are not yet adults, their guardians have responsibilities for their well-being but are also balancing the requirements of allowing age appropriate freedoms and privacies. Establishing and maintaining age-appropriate boundaries a major focus in all therapy, but especially in this age group. One boundary we must address immediately is: what is and is not shared about therapy encounters. Since the therapeutic relationship is the cornerstone of all healing in therapy and establishing that relationship requires mutual trust and respect with the presumption of safety and privacy, the content of sessions will not be revealed unless the adolescent is in imminent danger. For successful adolescent therapy, the guardian(s) will only be advised of the diagnosis, treatment goals, any referrals needed, and the overall progress of therapy. The specific content of sessions will not be shared without the minor's consent unless the minor is in imminent danger.

Controversial topics in adolescent therapy

Your adolescent may have questions about very controversial topics like: sex, specific sexual practices, sexuality, pregnancy, STDs, marriage, living together, drugs, drug use, addictions, taking psychotropic medications, religion, politics, money, or anything else an adolescent may wonder about. It is my policy to answer these questions factually, instructing on the spectrum of possible opinions/positions, inserting my clearly labeled opinions only if necessary, and encouraging the adolescent to discuss these topics with parents and guardians. I will not advocate one opinion without discussion of all possible opinions and potential consequences. I am an opponent of mis-information. My goal is to assist all my clients in developing critical thinking skills along with coping strategies to enable healthy growth and a happy, successful life.

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Appointments

You, your adolescent and your therapist will decide on mutually acceptable times to meet. You may make your appointments online at www.anneschanzphd.com. Therapy appointments are for a specified amount of time and must conclude on time, even if you are late. Your therapy time is reserved for you so please call to ***cancel or reschedule at least 24 hours in advance***. If you ***fail to provide 24 hour notice you will be charged the full fee*** **for the session which is not covered by insurance**.

Initial here_____

Emergencies

An emergency is an *urgent issue requiring immediate action*. Occasionally, an emergency requires telephone counseling. Your therapist is on call 24 hours a day, seven days a week and can be reached via emergency numbers provided to you. While you are encouraged to call in an emergency, please be informed that this office bills a *minimum half hour charge for emergency telephone counseling*. Insurance may not cover emergency telephone counseling sessions.

Initial here_____

Payment for Services

Payment is due at the time services are rendered. To simplify billing and reduce time used in your session to deal with payment issues, we will bill your session copays to the card on file, and file your insurance claims at the time of charting. You will be required to sign a payment agreement (attached) to assure you understand what we will charge and to authorize us to collect your payments. Please be aware that ultimately, you are responsible for all charges.

1. Insurance Issues

You must call your company benefits department or your insurance provider prior to your first visit to determine what your coverage, deductible and co-pay for mental health out-patient services will be. Please verify the network status of your therapist.

Coverage and Filing

If this office will be filing insurance for you, please be advised that ***verification of insurance benefits with your insurance carrier does not guarantee payment by your insurance company***. This office will bill your insurance company, however, if we do not receive payment after two (2) attempts to collect from them, the charge(s) will be transferred to you and the remaining balance will be your responsibility**. Your therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.** This office will supply you with statements that may be sent to your insurance company for reimbursement.

Confidentiality Advisory (see above)

In order to file your claims your insurance carrier will require information about your diagnosis and treatment plan. Different insurers require different levels of information. Please discuss this with your therapist if you have concerns. Some large companies are self-insured which means they are the ultimate payer for their insurance claims. Those companies have access to all the claim and managed care data, but have legal restrictions on how they may access it or use it.

Deductibles

In- network or out-of-network, you ***may have a deductible which must be paid before your insurance benefit starts***. Please be aware that at the beginning of your employer's fiscal year, or the beginning of a new year, annual deductible amounts start again and this amount is your responsibility. Contact your employer or insurance carrier to find out if you have a deductible and how much it is.

Co-payments

You are responsible for your co-pay at the time service is rendered. Co-pays vary by policy, and by service. Your co-payment is based on the health care policy selected by your employer or purchased by you. The co-payment amount may be listed on your insurance card. If not, you will have to contact your employer or insurance carrier to determine the amount.

In-Network vs. Out-of-Network Insurance coverage.

Either may require a deductible which must be paid by you before the insurance carrier pays any portion of the bill. HSA accounts and Flex plans can be used to cover this expense. Out-of-network generally results in higher co-payments from you, but may have fewer limitations on your therapy plan. I am not in-network with Cigna or UHC.

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2. Court Appearances/Document Production

In the event your records or your therapist's testimony is subpoenaed by a court, you will be responsible for all the costs of producing the documents, preparation for the court appearance, travel time to court and all time spent at the court house at a rate of $220/hour. *There is an eight (8) hour minimum payment for court appearances*, which must be paid in advance of such preparation.

Custodian of Records

Your therapist will maintain your records for five years, as required by Texas law. In the event your therapist should need to close his/her practice for a prolonged or permanent absence, your file will be passed to a new custodian for safekeeping. **By signing this document, *you are consenting to the transfer of your records to another licensed therapist, designated by your therapist, to preserve the confidentiality of your records.***

CONSENT TO TREATMENT

I, as legal guardian, voluntarily agree to allow my minor child to receive Mental Health assessment, care, treatment, or services and authorize the undersigned therapist to provide such care treatment or services as are considered necessary and advisable.

I understand that I, as legal guardian, will only have access to the diagnostic assessment and overall progress of my minor child (ward) toward treatment goals, not to the specific content of any session(s). I understand and accept that in order to establish the therapeutic relationship needed to facilitate change, my adolescent (ward) will need to be able to confide in the therapist knowing that those communications will be private. Therefore, I, as legal guardian, will not be privy to the specific content of any sessions, except if the minor is in imminent danger.

I, as legal guardian, understand that my adolescent may need to discuss controversial topics like sex, STDs, drugs and addictions. I further understand that Dr. Schanz will discuss any topics of concern to my adolescent by providing factual information along with a spectrum of opinions to facilitate reaching the treatment goals.

I, as legal guardian, understand and agree that my minor child and I will participate in the planning of his/her care, treatment or services, and that I may stop such care at any time.

By signing this Client Information and Consent form, I, the undersigned guardian, and I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____	_____	_____
Client's Signature	Client's Printed Name	Date
_____	_____	_____
Guardian's Signature	Guardian's Printed Name	Date

As Witnessed by:
Therapist, who has inquired about questions, confirmed that the client has read and understood the entire form and all questions have been answered to client's satisfaction.

_____	_____
Therapist's Signature	Date

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Statement of Legal Guardian

Guardian Information:

Name: _____ _____ _____
(First) (MI) (Last)

Address: _____ _____
(Street) (Apt.)

_____ ___ _____ DOB: _____ TDL # _____
(City) (St) (Zip Code)

Gender: ___ Age _____ Marital Status: ____ Relationship to child: _____

Telephone (cell) _____ (work) _____Email: _____

Preferred contact method: Email: __ Phone: ___ Text ____

Minor (client) information:

Name: _____ DOB: _____

Child's Primary Address and addresses of any other custodial person's contact information (if different from above) :

_____

_____

_____

Any additional information:

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Statement of Legal Guardian

I, _____, have the legal right to authorize counseling
(Name of Parent/Guardian)

for _____, DOB _____.
(Child's Legal Name)

1) I have ATTACHED CURRENT CUSTODY ORDERS PERTAINING TO THIS MINOR CLIENT,

2) I affirm that I have satisfied every legal stipulation, so that all required notifications and/or authorizations to or from other parties (legal parents, other guardians, etc.) have been made in accordance with **any, and all, court-orders pertaining to this minor client**.

3) I accept the responsibility to provide a completed Guardian Information Form to this office for anyone sharing custody of this minor, and/or required to be notified of this treatment by any court order.

4) Others authorized to have minor client information (name, phone, and email):

_____

_____

_____ _____
Printed name of Parent/ Guardian Date

_____ _____
Signature of Parent/ Guardian Date

_____ _____
Signature of Therapist Date

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Services Payment Agreement

	Individual	Couples	Group	Sliding Scale is available based on household income.
60 minutes	200	200	N/A	range: $ 85 - 200
90 minutes	300	300	50	range: $ 200 - 300

Please select your method of payment below:

1. **SELF PAY:** I agree to pay the sliding scale fee/session of:

   $_____ for individual

   $_____ for couple/marital/relationship

   $_____ for clarity classes

   which will be charged to my credit/debit/HSA/Flex card kept on file at the time of service (or charting) with **no insurance filing** by this office. Note: Classes are not covered by insurance.

   ____I need insurance/HSA filing forms emailed to me @ _____.

   ____I do not need any forms for filing.

2. **INSURANCE**: I request and authorize you to file my insurance claims for me. I understand that if my insurance does not pay *for any reason*, after two attempts to collect from them, full payment will be my responsibility. **I understand that this office DOES NOT verify your insurance coverage**. That is up to you.

   My **mental health insurance carrier** is: _____,

   Mental Health Insurance Phone #_____.

   ____ I have verified you are IN-NETWORK with my insurance carrier for mental health services.

   ____ I have verified you are OUT-OF-NETWORK with my insurance carrier for mental health services.

   ____ I have verified my mental health co-pay to be _____ per session.

   ____ I have verified my deductible amount to be $ _____ per year. Met to date: _____

   ____ I need HSA/Ins filing forms for each payment emailed to: _____

   ____ I do NOT need HSA/Ins filing forms.

3. **EAP (Employee Assistance Program)**

   Employer_____

   EAP Company _____ Phone_____

   Authorization Number _____ # Sessions Authorized _____ Dates: _____ to _____

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Payment Account Authorization:

I, _____ (print name), authorize you to keep this debit/credit card on file and charge this account, detailed below, for the amount due on my account according to the Services Payment Agreement above.

Name on Card: _____ circle type: Credit Debit HSA Flex Other

Billing address: _____

City _____State _____zip _____

Card number: _____

EXP date: _____ CVV: _____

Signature: _____ Date: _____

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Trinity Square Plaza
2828 Trinity Mills, Ste. 106
Carrollton, TX 75006

Directions:

From the Tollway:
Take the PGBT West exit, proceed on PGBT to take the Marsh exit, proceed on Marsh to Trinity Mills, turn left, the office is in the first 3 story building on your right.

From I-35:
Take the PGBT East, exit Marsh, Turn right (south) on Marsh, proceed to Trinity Mills, turn left, the office is in the first 3 story building on your right.

Inside Trinity Square Plaza

We are on the first floor, suite 106. It is at the end of the hallway, located north or the elevators, also where the restrooms are located.

Before 6:00 pm, use the front entrance, proceed across the lobby, take the first hallway to the right (before the elevators) and proceed to the end of the hall to suite 106. You will pass the restrooms.

The building locks at 6:00 pm, after 6:00 pm, you must use the REAR ENTRANCE.

At the rear entrance use the telephone to contact security. Tell them you are coming to suite 106. There is a password, 'red balloon'. If it has changed, please text me at 972-822-5901. Go to the hallway on your right, just past the elevators and follow that hallway to the end, suite 106.

In the Northeast corner of the building lobby/atrium there is complimentary coffee and tea available. There are also vending machines with drinks and snacks.