Welcome to my practice! I appreciate and value this step you have taken towards your treatment, and I look forward to working with you. I have prepared a description of my services and an explanation of my policies in order to help you better understand what to expect from me. Please read the following information and ask questions as needed.

SERVICES

I am a board-certified psychiatric mental health nurse practitioner in the state of Texas. I offer psychiatric consultation, individual psychotherapy with and without medication management, and medication management. I use evidence-based practices for both psychotherapy and psychopharmacology. I am conservative in the use of psychotropic medications and prescribe it only if clinically warranted. Mood can be significantly impacted by nutrition and fitness. I use a holistic approach which includes, evidence-based practice as well as the use of supplements, exercise, and nutrition to maintain a healthy emotional state of mind. If you have an individual therapist, I offer medication management in close collaboration with your therapist.

PHILOSOPHY

My approach is collaborative, working together with the patient towards his or her individual goals. I am a firm believer in the therapeutic value of establishing a trusting and respectful relationship with my patients. I focus my efforts on getting to understand the patient first, with a

holistic and gentle approach, prior to formulating a treatment plan. My approach is thorough, exploring a patient's biological, psychological and social factors, prior to determining the next best step, which may or may not include medications.

TREATMENT APPROACH

The initial sessions typically serve to help me understand more about you and understand your current problems, concerns and needs. I will provide you my clinical impressions and initial opinions about approach to treatment. If you decide to continue to work with me for treatment, at this point, I will provide you with my working understanding of the problem, as well as treatment options and therapeutic objectives. During the course of treatment, I may utilize various psychotherapeutic approaches as well as medication recommendations.

CONFIDENTIALITY

Patient confidentiality is very important to me. To ensure your confidentiality, if I see you in public, I will not acknowledge you unless you acknowledge me first.
I will not share your medical records with anyone without specific authorization and written consent from you, excepting in the following circumstances:
In my professional opinion, you are at risk for seriously injuring or killing yourself. In this circumstance, I am ethically and legally required to work with the patient to prevent this from occurring. The plan of action could include developing a safety plan with family members or others who can help provide protection, arranging for hospitalization with a patient's consent, or in the event of an emergency, facilitating involuntary hospitalization.
In my professional opinion, you are at risk for seriously injuring or killing someone else. In the event that there is an identifiable person or persons at risk, I would take preventative and protective actions to protect others from harm. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization, even if involuntary, for you.

There is reason to suspect a child, elder (age 65 or older), or a dependent adult is being neglected or abused. In these circumstances, the law requires that I file an immediate report with protective services or the appropriate state agency.
Occasionally, I may have to consult other professionals about your illness or treatment options. During a consultation, I will make every effort to avoid revealing your identity to the consultant. The consultant is also legally bound to keep the information confidential.
When I am unavailable (i.e., on vacation, extended sick leave, family emergency), I will provide limited information to a clinician covering for my services.
All mental health professionals are required to keep professional records, which is critical for continuity of care. Although I will make every effort to safeguard your privacy, records may be subpoenaed by a court of law.
I may also be obligated to disclose relevant information regarding your care in order to defend myself, should there be a complaint or lawsuit filed against me.

APPOINTMENTS AND CANCELLATION POLICY

Because every patient is important to me, I will not be able to keep other patients waiting if you are late for any reason. Therefore, I suggest that you try to be here a few minutes early so that you are able to keep your appointments start and end at their scheduled times.
I have a 24-hour cancellation policy. Please notify us Monday through Friday at least 24 hours before your follow-up appointment, or at least 48 hours before your new client appointment. Please note that you will be responsible for payment of my fees if you cancel your appointment less than 24 hours of the appointment. If I ever have to cancel your appointment with less than 24 hours-notice to you, I will waive my fee for that rescheduled appointment.
If we do not receive your cancellation in time, we charge a $60.00 fee for missed follow-up appointments. In the rare case that a new client appointment is missed, a $100.00 fee is charged.
Insurance does not cover missed appointments. Frequent missed and/or cancelled appointments may cause us to refer you to another provider for care.

FINANCIAL POLICY

Payment is due at time of service.

If you plan to pay through credit card, you must complete a credit card authorization form during the initial visit. Your credit card will then be billed for regular appointments as well as late cancellations and telephone services.

If you will be filing statements with insurance, upon request, I will provide you with the necessary statements along with the diagnosis code.

FEES

Fees for the initial consultation will be billed at $175 and will typically last for 60 minutes. For more complicated issues, additional time may be required. This is billed at $40 per 15-minute increments.

Fees for follow-up appointments, which include judicious treatment with psychiatric medications, if indicated will be billed at $150 and will typically last for up to 30 minutes. If additional time is needed, the billing will be at $40 per 15-minute increment.
I do not fill medication requests over phone and recommend that you schedule an appointment instead.
I do accept insurance panels including Blue Cross Blue Shield, United Healthcare, Aetna and Cigna. You may wish to check with your insurance carrier prior to scheduling an initial appointment regarding your behavioral/mental health benefits.

TELEPHONE POLICY

I generally address clinical issues only during therapy appointments. If there is an urgent issue that you would like to discuss, please schedule an appointment. I do not bill for any phone calls relating to scheduling or billing.

LITIGATION

Due to the nature of the therapeutic process, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at

any other proceeding, nor will a disclosure of the psychotherapy records be requested unless we agree otherwise. In the event that you become involved in legal proceedings that mandate my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, my fee is $350 per hour for preparation, attendance, and travel to/from any legal proceedings.

EMERGENCY SERVICES

I try my best to return phone calls within 24 hours. However, particularly if you have called on the weekend or in the evening hours, it might take longer than 24 hours until you are able to hear back from me. If you are in an emergency situation or require urgent attention, please call 911 or go to the nearest emergency center.

MEDIA AND SOCIAL MEDIA

I am active in blogging and social media. Please note that any of my opinions expressed on any form of public media, including social media (blogs, Facebook, Twitter, Instagram), are not considered to be personal medical advice. Patient advice will not be provided in media or social media and should be restricted to patient visits or telephone calls. Any references that I may make in the media or social media are never patient specific and are always generalized and fictionalized.

I have read the practice policies notice and have been given time for questions. I understand the practice policies.

PATIENT NAME : ____
PATIENT DATE OF BIRTH : ____
PATIENT SIGNATURE : ____
TODAY'S DATE : ____

REGISTRATION FORM

PATIENT NAME : ____
STREET | CITY | ZIP : ____
PHONE : ____
PATIENT E-MAIL : ____
PERMISSION TO CALL? : ____
PERMISSION TO E-MAIL? : ____
PATIENT DATE OF BIRTH : ____
GENDER : ____

EMERGENCY CONTACT

NAME : _____________________________________
RELATIONSHIP : _____________________________
TREET | CITY | ZIP : __________________________
PHONE : ___________________________________
E-MAIL : ____________________________________

MindSet Solutions and Wellness Center, LLC
3245 Main Street, Suite 114, Frisco, TX 75034
Office (469) 405 8889/www.mindsetsolutionsandwellnesscenter.net

INSURANCE

WOULD YOU LIKE ME TO E-MAIL YOU OR HAND YOU THE INSURANCE STATEMENT?

____

PRIMARY INSURED PERSON'S NAME: ____

PRIMARY INSURED PERSON'S DATE OF BIRTH : _______________________________

PRIMARY INSURED PERSON'S STREET | CITY | ZIP : ___________________________

PHARMACY

PHARMACY NAME STREET | CITY | PHONE : __________________________________

____

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME :___________________________________
PATIENT DATE OF BIRTH :___________________________
NAME ON CARD :__________________________________
ACCOUNT NUMBER :_______________________________
TYPE OF CARD :__________________________________
EXPIRATION DATE :_______________________________
SECURITY CODE :________________________________
BILLING ZIP CODE :_______________________________

By signing this form, you authorize MindSet Solutions and Wellness Center, LLC to charge your card for fees as discussed due on a recurring basis, with receipts and insurance statements to be e-mailed to you.
This authorization may be revoked at any time by contacting and informing MindSet Solutions and Wellness Center, LLC via e-mail, text, telephone or in person.

YOUR NAME : ___________________________________
SIGNATURE : ___________________________________
TODAY'S DATE : ________________________________

MindSet Solutions and Wellness Center, LLC
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MY RESPONSIBILITY

- Maintain the privacy of your information.
- Provide you with a notice that explains our legal duties and privacy practices.
- Abide by the terms of this notice.
- Notify you if I am unable to agree to a restriction that you request.
- Accommodate reasonable requests you may have to communicate health information by alternative mans or locations. We reserve the right to change practices and make new provisions.

I have read the notice of privacy practices for protected health information and have been given time for questions. I understand that MindSet Solutions and Wellness Center, LLC will not release my health information unless I give written permission or when required by law.

PATIENT NAME : ____
PATIENT DATE OF BIRTH : ____
PATIENT SIGNATURE : ____
TODAY'S DATE : : ____