Karl F. Neumann, Ph. D.
1700 Alma Drive, Suite 205
Plano, Texas 75075
(972) 509-2611

OFFICE POLICIES INFORMATION SHEET

Welcome to the psychology office of Karl F. Neumann, Ph.D. This office offers a variety of individual, marriage, family, and group psychotherapies for adults as well as children. Also available are evaluation, consulting, and forensic services. In answer to frequently asked questions and to insure your understanding of our office policies, *we ask that you read the following information and sign your name to indicate your understanding.* Should you have any questions, please feel free to ask your doctor.

1. Therapy sessions begin by appointment and are 45 to 60 minutes in length, varying in accordance with service codes required. The time and length of evaluation, consulting, and forensic sessions are arranged on an individual basis.

2. The fee for the initial therapy session is $175.00. Subsequent therapy sessions are $150.00 Evaluation, consulting, and forensic fees are determined on an individual basis. Special fee schedules may apply if you are part of a PPO or other managed care group.

3. Full payment for each session is requested at the time service is to be rendered unless prior arrangements have been made. Pre-payments are accepted. Payment may be made by cash, check, and most credit or debit cards. A $35.00 fee will be charged for any returned check.

4. Your session time is reserved for you. If you are unable to be there for your appointment , you are asked to notify our office at least 24 hours in advance so that someone else may utilize this time. In the absence of our notification, you will be billed for the missed session. *Insurance is generally not responsible for this bill, so you will be billed for the full fee amount.* Further, if you miss a session and do not call to reschedule, we will assume that you have terminated therapy.

5. If you are filing your own insurance and would like a receipt for payment in addition to your cancelled check, please request this at the time of your payment.

6. No outstanding fees of over $290.00 for which arrangements for payment have not been made will be allowed. You are responsible to pay this before further service will be provided. If your financial status prohibits further treatment with us, we will be happy to refer you to alternative agencies.

7. All delinquent accounts for which full payment has not been received (nor alternative arrangements for payment made) may be turned over to a collection agency. Persons who fall into this category will be responsible to pay all costs incurred in the collection process.

8. The benefits obtained from psychological services are dependent on many factors, and no guarantees regarding the effectiveness of these services are offered. The therapeutic process involves both the commitments of you as the patient and your doctor.

9. Psychological services are confidential in most circumstances. Please be aware, however, that you or your family's records are not confidential in the following circumstances: child custody disputes, civil law suits where psychological functioning is part of the claim, criminal lawsuits where records are subpoenaed, child safety is of concern, or an impending act is planned by you or a family member that could cause harm to persons known or unknown. If insurance is paying some or all of your bill, be aware that your diagnosis, dates of service, and other information will be provided to the insurance company to secure payment if you authorize us to do so. Please ask your doctor any questions you might have about this information.

10. All patients give consent for the psychologists and staff in this office only to consult with each other as needed to provide the best possible services. In an emergency, the psychologists and staff in this office have permission to contact you as needed.

I have read, understand, and agree to abide by the above Office Policies Information Sheet. I have received a copy of the Texas Notice Form.

_____ _____

Signature Date

CLIENT INFORMATION

Name_____ Nickname_____
Date of Birth_____Age_____ Employer_____
Home Address_____ Office Address_____
City_____State____Zip_____ City_____State___Zip_____
Home Phone _____ Business Phone _____
Cell Phone _____ Preferred contact: Home Business Cell
Can we leave you a message at this number?_____

Family Physician_____ Address_____Phone_____
Referred by_____ Address_____Phone_____

Emergency Contact_____ Relationship to Client_____
Phone _____ Alternate Phone _____

Who is financially responsible for services?_____
Relationship to Client_____ Employer_____
Address_____ Business Address_____
City_____State____Zip_____ City_____State____Zip_____
Home Phone _____ Business Phone _____
Cell Phone _____
Date of Birth_____Age_____

If we are filing insurance for you, please complete and sign the following:

Company Name_____
Claims Address_____
City_____State_____Zip_____
Benefits Phone _____
Subscriber ID#_____
Group #_____

I hereby assign all pertinent medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to: Karl F. Neumann, Ph.D. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid for by said insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Signed_____ Date_____

INTAKE SHEET

- Brief statement of problem or services requested: _____
- Who referred you? _____
- For each person currently living with the client (including the client), please list the following information:

Name	Birthdate/ Age	Client/Relation to the Client	Years of Education	Occupation	Marital Status/Years Married	Previous Therapy

- For each person currently living with the client (including the client) who is using any drug for any reason, please list all prescription and nonprescription medication:

Name	Condition Being Treated	Treatment Provider	Medication & over-the-counter medication	Amount

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) a day or two before your scheduled appointments.

You will continue to schedule or change appointments in person or by telephone at 972-509-2611.

Client name: _____

Parent name (if client is a minor): _____

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (**check only one**)

_ _ Via a text message on my cell phone (normal text message rates will apply)

_ _ Via an email message to the address listed above

_ _ Via an automated telephone message to my home phone

_ _ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. I understand that e-mail communication is not encrypted, and as such is not considered completely secure.

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Signature Date

Karl F. Neumann, Ph.D.

Clinical Psychology

1700 Alma Drive, Suite 205
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(972) 509-2611
Fax (972) 578-5742

Email Notice

It is important to be aware that email communication can be relatively easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all email messages that go through them. Unencrypted emails are even more vulnerable to unauthorized access. Please be aware that all email communication with Dr. Neumann is unencrypted.

Please notify Dr. Neumann immediately if you decide to avoid or limit in any way the use of email. Please do not use email for emergencies.

It is important that you understand that Dr. Neumann does not provide professional advice through email. If you choose to send personal information via email that you feel relates to your therapy or that you think is important for Dr. Neumann to know, it will be discussed in your next therapy session, not through email.

By signing below, I acknowledge that I've read and understood this email notice. I give consent for Dr. Neumann to contact me through email.

_____ _____

Signature Date

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

_____ Date: _____

Signature of Patient/Patient's/Legal Representative