Mindy McGuire, Ph.D., L.C.S.W.

104 SW 11th Avenue
Delray Beach, FL 33444
(561) 859-4568
Dr.Mindy@Outlook.com
https://www.psychologytoday.com/profile/392913

HIPAA Notification

Welcome. This document (agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that your signature is obtained acknowledging that you have been provided with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before your next session. You may revoke this agreement in writing at any time. If you choose to revoke your consent, please make sure that you mail us such document revoking this agreement to our offices. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Please read it carefully and write down any questions you might have so that we can discuss them at your next meeting. When you sign this document, it will represent an agreement among you and your therapist.

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Psychotherapy Services Agreement

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things discussed both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees of what you will experience.

Your first few sessions will involve an evaluation of your needs. We reserve the right to assign a certain evaluator or therapist to you for your evaluation or continuing therapy. By the end of the evaluation, we will be able to offer you some first impressions of what your work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable with working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures you should discuss them whenever they arise. We will be happy to help you set up a meeting with another mental health professional for a second opinion if your doubts persist,

Your signature below indicates that you have read the agreement and agree to abide by its terms during our professional relationship. Your signature below also indicates that you have received the HIPAA Notice form.

Signature of Client ____________________________________ Date ___________

Print Name ________________________________

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Client Registration

Name(s): ____

Address: ____

____

City: ____ **State:** _______ **Zip:** _______

Phone (H): ______________________**Work:** _______________ **Cell:** _____________

Is it acceptable to leave a voicemail message or text? (Circle one) Yes No

Client or Parent/Guardian if a child/teen
Email: ____

Is it acceptable to correspond via email? (Circle one) Yes No

If you are here as a couple or family, please provide please provide any additional contact information not written above.

Name(s): ____

Phone (H): ______________________**Work:** _______________ **Cell:** _____________

Is it acceptable to leave a voicemail message or text? (Circle one) Yes No

Patient or Parent/Guardian if a child/teen
Email: ____

Is it acceptable to correspond via email? (Circle one) Yes No

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Emergency Contact Name: ____

Emergency Contact Phone: ____

Referred by: ____

If applicable, do you consent to permit Dr. McGuire to thank your referral source for referring you to her. This communication will ONLY consist of a thank you:

___ Yes (if yes, please sign below)   ____ No   ___ Not applicable

Signature of Client ____________________________________ **Date** ___________

Print Name ________________________________

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Appointment Cancellation Policy

Appointments must be cancelled at least 24 hours in advance via text to (561) 859 – 4568, in order to avoid paying for the session. If an appointment is missed, you will be billed for the appointment time that was reserved. The first missed appointment will be waived.

I have read and agree to the terms of the Appointment Cancellation Policy as described above.

Signature of Client ______________________________________ **Date** ___________

Print Name __________________________________

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Office Policies and Procedures

In order to simplify my office procedures and provide the most effective care, I am providing you with the following office guidelines.

Appointments

Barring rare emergencies, I will see you at the scheduled time. Initial evaluations are 60 minutes in length. All therapy sessions are typically 60 minutes long. The last 5 minutes of the session will be spent addressing any necessary paperwork, follow up or care management concerns, and to schedule the next session. If we contract for a “double” session, please note that this is an hour and a half. If you are late, the time will be lost from your appointment. If you cannot keep an appointment, please give me at least 24 hours notice, or you will be billed for the appointment. This may be waived in some situations such as inclement weather, illness, or emergencies. This therapist will recommend a frequency of treatment based on your specific needs. Optimal outcomes from treatment can only be achieved if you take responsibility in your care and are compliant with the therapist’s recommendations. Repeated cancellations may result in you being discharged for noncompliance.

Availability for Emergencies

I do not have a formal emergency service, but I can be reached at (561) 859 – 4568. I check my texts throughout the day and less frequently during the evening and weekends. I will return calls as promptly as possible.

Fees

See attached fee schedule for fees associated with treatment. I am not a member of any HMO or PPO panels. If you are seeking reimbursement for fees paid for services from your insurance company, you are responsible for contacting the company to determine the extent of your coverage. I will prepare an invoice to be submitted to your insurance company and will make every attempt to facilitate insurance reimbursements. You are ultimately responsible for all expenses you incur. Fees are due at the time of the session

as per previous descriptor in this admission packet.

Confidentiality

All therapy is considered confidential. All of your treatment records are kept in private files. They are considered work notes and are not sent out when records are requested unless you specifically request this in writing. I may be required by law to make exceptions to confidentiality in narrow circumstances such as child abuse or danger to another person or to yourself. Your insurance company may require certain information in order to provide reimbursement. In addition, I may consult with other professionals who are involved with your care if you give your consent. If you think there is any chance that your therapy records may become part of legal proceedings in situations such as custody evaluations, divorce, please discuss this with me before you begin treatment. You retain the right to request your records for transfer or legal proceedings you initiate. All care will be in compliance with the HIPAA privacy act.

Thank you for your cooperation.

This is to affirm that I have read and understand the foregoing.

Signature of Client ____________________________________ **Date** ___________

Print Name ________________________________

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Fee Schedule

Services	Time	CPT	Fee
Initial Assessment	1 hour	90791	$200
Individual Therapy	1 hour	90834	$200
Couples Therapy	1 hour	90847	$200
Family Therapy	1 hour	90847	$200
10 session package (pay ahead)	10 hours total	90834	$1750

Note, appointments are 60 minutes long, and the last 5 minutes at the end of the session will be used to address any necessary paperwork, follow up/care management, and to schedule the next session.

I the undersigned have been made aware of the fees for services as per above by my therapist and have been offered a copy of this document.

Signature of Client ______________________________________ **Date** ___________
(13 years or older)

Print Name _________________________________

Signature ____ **Date** ___________
(Parent/Guardian/ Responsible Financial Party)

Print Name _________________________________

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Billing and Payment Policy

Accepted forms of payment:

Cash and Credit Cards
* personal checks are not accepted *

Payment information is required in order to make an appointment.

Credit Card______________________________ Expiration Date____________________

Clients are billed after each session for services rendered. It is policy and a requirement for services to be given to you for us to keep a copy of a credit card on file and be authorized to charge the monthly total of unpaid balance.

I, _____________________________, (print name) authorize Mindy McGuire to charge my session balance to the credit card that I have provided. I understand that my balance will be billed for any fees unpaid.

I, _____________________________, (print name) authorize Mindy McGuire to charge my credit card that I have provided to her for sessions and services rendered to the following persons specified below:

Name(s): ____

I fully understand, acknowledge and agree that the balance due and owing to Mindy McGuire will be billed without interruption for any and all of the sessions received by myself or anyone I have specified above and that I shall be unconditionally liable for the payment of those sessions, costs, expenses or fees that are due and owing or are unsettled. I also hereby agree to abide by all of the provisions of my credit card agreement in making such payments. If I choose to make any changes to the financial agreement, I am agreeing to notify Mindy McGuire in writing via email or text, 14 days prior to such

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change so that a new method of payment can be substituted or agreed to by me and Mindy McGuire. I shall be solely responsible for any and all costs and fees associated with collections of any unpaid balance to Mindy McGuire. Any disputes arising out of payments, cost and or fees associated with services rendered shall be resolved in Palm Beach County Florida and under the laws of the State of Florida.

I have read and agree to the terms of the Billing and Payment Policy as described herein:

Signature ____ **Date** ___________
(Responsible Financial Party)

Print Name _________________________________

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Credit Card Authorization Form

Card Type:
- ☐ Visa
- ☐ MasterCard
- ☐ American Express
- ☐ Discover
- ☐ Other ___________

Cardholder Name: ____

Credit Card Number: ____

Expiration Date: ____

Billing Zip Code: ____

I, the undersigned cardholder, authorize the merchant Mindy McGuire, Ph.D. LCSW to charge my credit card for purchases related to services. I agree that my information may be saved by the merchant for future payments and understand that this can be revoked at any time upon written request.

Signature of Cardholder________________________________ **Date** ___________

Print Name ________________________________