MoryTherapy **Bill Mory, Ed.S. L.P.C., L.M.F.T.**

Marriage, Family and Individual Counseling Services | Mindfulness Training/ Emotional Brain Training

CANCELLATION WITH NO 24 HOUR NOTICE: *As a result of an increase in no-show and no-notice cancellations in 2019, we have implemented a $75.00 fee for no-show appointments, and for cancellations with less than a 24 hour notice. If a credit/debit card has been provided, the card will be used for this fee unless you indicate another form of payment. Proper notice for cancellations may be given by calling or sending a text message with your full name to 903-624-3960, or by sending an email to morytherapy@gmail.com. Thank you for your consideration.*

Thank you for choosing MoryTherapy.
We are glad you have taken this step and will work diligently with you in the counseling process to help you achieve your goals.

If you have any questions about information from your insurance carrier or how your insurance will be applied please contact the Practice Administrator at 903.819.4449.

Below are some things you will need to do *prior to your first visit*.
Please read and DO ALL items. Thank you !

CALL YOUR INSURANCE CARRIER:

1) Ask if you have a Deductible to meet prior to using your Behavioral Health benefits.
2) Ask if you have a Coinsurance (%) or a Co-pay ($) that you will need to pay at each visit.
3) *Please be prepared to pay these amounts at your first visit.*

BRING YOUR INSURANCE CARD TO FIRST VISIT:

1) Services may be billed to you directly if you do not provide your insurance card **at your first visit**.
2) Claims cannot be submitted to your insurance carrier without a copy of **both sides** of your insurance card.

EMPLOYEE ASSISTANCE PROGRAM (EAP):

1) Ask your employer if you have an Employee Assistance Program (EAP). If so, the first few visits may be paid in full by this plan. Call the EAP BEFORE YOUR FIRST VISIT AND BRING: 1) the authorization number 2) the number of visits authorized

REMEMBER ...

- **COMPLETE ALL BOXES AND PAGES OF THIS PACKET.**
- **COMPLETE INFORMATION HELPS US TO SERVE YOU BETTER.**
- **SIGN WHERE INDICATED.**
- **KEEP THE NOTICE OF PRIVACY PRACTICES (LAST 5 PAGES)**

CLIENT ACKNOWLEDGEMENT (Required)

Signature: _____ Printed Name: _____ Date: _____

MoryTherapy **Bill Mory, EdS, LPC, LMFT** **Today's Date**: _____

CLIENT INFORMATION

Last Name: First Name: Middle Initial

Birth Date: Age: Gender Identification: ☐ Male ☐ Female Other:

Physical Address: City State ZIP

Social Security Number:	Cell Phone Number:	Home Phone Number:
Occupation:	Employer Name:	Employer Phone Number:

Current Primary Relationship Status:
☐ Single or Never Married ☐ Married ☐ Living with Partner, unmarried ☐ Separated ☐ Divorced ☐ Widowed

PAYMENT INFORMATION

HOW WILL YOU PAY FOR SERVICES: ☐ Self-Pay ☐ Employee Assistance Plan ☐ Health Insurance ☐ Medicaid

Person responsible for service bill: Last Name: First Name: Middle Initial

Birth Date: Age: Relationship to client:

Physical Address: City State ZIP

Social Security Number:	Cell Phone Number:	Home Phone Number:
Occupation:	Employer Name:	Employer Phone Number:

INSURANCE INFORMATION: COPY OF CARD IS REQUIRED AT FIRST VISIT

Name of Primary Insurance Company: Phone Numbers on back of Card:

Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date: Age:
Subscriber ID #:	Group #:	Employer Name:

Relationship to client:

EMPLOYEE ASSISTANCE PROGRAM (EAP) THROUGH EMPLOYER

EAP Company Name: EAP Phone Number:

Authorization Number: Number of Visits Approved: Expiration Date to Use Visits:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Cell Phone Number:	Work Phone Number:

Physical Address: City State ZIP

Relationship to client:

CARD PAYMENT INFORMATION

Type of Card: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ OTHER: _____

Name on Card: Card Number:

Expiration Date: Code on Back (CCV): Zip Code on Account:

Relationship to client: ☐ SELF ☐ SPOUSE/SIGNIFICANT OTHER ☐ PARENT/GUARDIAN ☐ FRIEND ☐ OTHER:

ASSIGNMENT OF BENEFITS: I authorize William (Bill) P. Mory, EdS, LPC, LMFT and representatives to release any information required to process my insurance and Employee Assistance claims. I authorize my insurance benefits to be paid directly to William (Bill) P. Mory. I understand that I am ultimately responsible for payment of all charges regardless of insurance coverage. *I understand that I will be charged $75 for any No Show or Cancellation without 24 Hour Notice for a scheduled appointment, regardless of reason, and I have provided the Card Payment Information above for the purposes of paying for and authorizing such charges.* I have read and understand the Consent for Services document as well as the HIPAA document and have been offered a copy of both. **SIGNATURE:** **DATE:**

SECONDARY INSURANCE INFORMATION: Card Is REQUIRED at first visit

Name of Primary Insurance Company: Phone Numbers on back of Card:		
Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date: Age:
Group Number:	Employer Name:	Employer Phone Number:
Relationship to client:		

BEHAVIORAL HEALTH HISTORY AND CURRENT STATUS

What is the primary concern that brings you to counseling?

How long have you experienced this issue?

☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ More than 1 year

Have you ever sought treatment for or do you currently suffer from any of the following conditions?

	PAST	PRESENT	NEVER	NOT SURE	DETAILS AND COMMENTS
Schizophrenia	☐	☐	☐	☐	
Personality Disorder	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	☐	
Posttraumatic Stress Disorder	☐	☐	☐	☐	
Anxiety Disorder	☐	☐	☐	☐	
Obsessive Compulsive Disorder	☐	☐	☐	☐	
Phobias	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	
Sleep Disorder	☐	☐	☐	☐	
Chronic Pain	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Cardiovascular/Heart Disease	☐	☐	☐	☐	
Head Injury	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	

Briefly list any previous counseling experiences you have had:

Briefly list any hospitalizations you had in the past 10 years: (Include medical, psychiatric, chemical dependency)

What changes would you like to see as a result of counseling?

CLIENT AGREEMENT AND INFORMED CONSENT FOR SERVICES

Overview of Services: William (Bill) Mory is a Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) who is licensed by the State of Texas. He provides professional counseling to clients in an outpatient office setting. Counseling is a collaborative process between you and a counselor to work on areas of your life and assist you with life challenges and goals. It is highly personal and at the same time is it is a contractual agreement so it is important to understand how the relationship will work and what both can expect.

To be most effective, it is important that you take an active role in the counseling process. Counseling activities by an LPC or LMFT are governed by the Texas State Board of Examiners for Professional Counselors and the Texas State Board of Examiners of Marriage & Family Therapists. Psychotherapy services usually take place once a week, once every two weeks or once a month, depending on the clients needs. Counseling, therapy and psychotherapy all refer to a supportive and guiding relationship with a professional practitioner who has undergone extensive training and personal exploration to understand the dynamics of human experience and psychological development. There are many different approaches, philosophies and modalities of psychotherapy and Bill Mory will offer his own unique approach to treatment in unison with your goals, desires and preferences.

Benefits: There are number of benefits possible from active participation in psychotherapy. It can simply be helpful to know that someone understands the challenges you are facing. Therapy can provide a fresh perspective on a difficult problem or point you in the direction of a new solution. The benefits you obtain from therapy depend on how well you use the process and put into practice what you learn. Some of the benefits from therapy can include: attaining a better understanding of yourself and your personal goals, developing skills for improving your relationships, overcoming specific problem areas such as depression, anxiety or compulsive behaviors, and finding resolution to the concerns which led you to seek therapy. However, there are no guarantees about what therapy will do for you. Some people find that participating in psychotherapy results in changes that were not anticipated or intended at the outset.

Risks and Expectations: There are certain risks associated with the counseling process and psychological treatment that should be understood before work progresses. For example, in counseling, there is a risk that clients will, for a time, experience uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other difficult feelings. Clients may recall unpleasant memories, distressing or upsetting thoughts or major changes in life perspectives that may affects significant relationships, jobs or understanding of yourself. Significant relationships may experience varying degrees of tension. This is often most prevalent within family relationships, but may extend beyond into one's social and professional life. Sometimes, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making significant changes in their lives. Even with our best efforts, there is a risk that therapy may not yield the results that you initially desired from it. For the most part though, counseling requires much effort, pain and struggle and therapy marks a season of growth, progress and healing in a person's life. It is always left up to the client to decide if the gain is worth the potential pain along the way.

Therapeutic Relationship: The client-therapist relationship may develop with a close emotional or psychological bond, however, at all times your relationship with Bill Mory is a professional one in which appropriate boundaries are maintained. Contact with Bill is limited to counseling sessions. Please do not invite Bill Mory to social gatherings, offer gifts, ask for written references or relate to you in any way other than the professional context of our counseling sessions. You are best served if counseling sessions concentrate exclusively on your concerns.

Client Rights: Some clients need only a few counseling sessions to achieve their counseling goals; others may require more time. As a client, you are in complete control and may end our counseling relationship at any time, though it is asked that you participate in a termination session. You also have the right to refuse or discuss modification of any of the counseling techniques or suggestions that you believe might be harmful or not beneficial to you. Services will be rendered in a professional manner consistent with accepted clinical, legal and ethical standards. If at any time you are dissatisfied with services please let Bill Mory know. You may address grievances regarding the counseling process with the Texas State Licensing Board at Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800-942-5540.

Emergency / Crisis Situations: If you have a life-threatening crisis or other emergency please call 9-1-1. Help is also available via the local mental health crisis line 24 hours a day at 877-277-2226. Bill's cell phone is not monitored for emergency calls.

Counseling via Technology: Methods of providing technology-assisted distance counseling services are evolving all the time. Bill Mory is committed to utilizing these means ethically and therapeutically. Based on guidelines from the National Board for Certified Counselors, common methods can include: telephone-based, email-based, chat-based, video-based, social network-based. Bill will determine on a case by case basis whether or not technology-assisted services is appropriate to utilize. Insurance plans may or may not pay for technology-assisted services. In order to utilize any of these technologies for counseling, clients are expected to agree to and abide by the following:

- Be an established client with intake paperwork, payment information, and an emergency contact/face sheet on file
- Be within the state of Texas, unless 1) you are a resident of Texas but you are temporarily located outside the state, 2) are a client newly relocated outside of Texas and experience an emergency, 3) are located on a US military base.
- Have a release of information for an emergency contact for the location from which you will be calling.
- Assume responsibility for securing a location to speak with me that is confidential.
- Understand when communicating via technology, confidentiality cannot always be guaranteed
- Understand that when visual cues (video) are unavailable, misunderstandings can occur
- Understand that technology-based sessions are not recorded or preserved by me in any way.
- When engaging in counseling via technology you acknowledge the risks and hold William (Bill) Mory, EdS, LPC, LMFT harmless.

Confidentiality: Psychotherapy, counseling, assessment, and associated services that are related to diagnosis, evaluation, and treatment services provided by licensed professionals are confidential and protected under Texas state law. The law protects the privacy of all communications between a client and a licensed professional. In most situations, information regarding your treatment can only be released to others with your written permission. However, there are legal limits to confidentiality and times when a licensed professional is obligated to disclose pertinent information, as necessary, to the appropriate authorities/agencies/individuals, as follows:

- If your therapist suspects that you pose a harm to yourself or others.
- If you report that a child, elderly person, or anyone else who cannot otherwise protect themselves has been or is being neglected or physically or sexually abused.
- Ordered disclosure by state or federal courts.
- Parents or legal guardians of minors have access to their child's records, unless emancipated.

You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA), which insures the confidentiality of all electronic information about you. When communicating with Bill Mory via email, it is necessary to understand that email may not be completely confidential.

If you are seen in public by Bill Mory or other staff members of MoryTherapy, your confidentiality will be protected by acknowledging you *only if you approach first*. In the case of marriage and family counseling, information you disclose without your family member knowing it will be kept confidential. However, open communication is encouraged between family members and Bill Mory reserves the right to terminate the counseling relationship if a secret is determined to be detrimental to the therapeutic process.

Referrals: Should you and/or Bill Mory determine that a referral is needed, you will be provided a referral to an alternative therapist or program to assist you. In this case, you will be responsible for contacting and evaluating those referrals and/or alternatives.

Time Parameters: Appointments are scheduled for 50-minute office visits. Given there is normally another client waiting for the next appointment, being late for an appointment will count towards your allotted appointment time and your session will still conclude at its normal end time.

Cancellation: Your appointment time is reserved for you. In the event that you need to cancel an appointment for any reason, please notify Bill Mory at least 24 hours in advance of your appointment time. You may cancel by calling Bill or sending him a text message with your full name to 903-624-3960 or by sending an email to morytherapy@gmail.com. Missed sessions without 24-hour notice are subject to a $75.00 fee.

Fee Structure:

- Private Rate: The cost of each 50- minute psychotherapy/counseling office visit is $100.00
- Insurance Rates: Bill Mory is 'in-network' with many insurance plans and employee assistance plans and contracts with those plans for specified rate for services rendered. Check your plan for your cost.
- No Show Charge: The cost of missed office visits without the required 24-hour notice is $75.00.
- Returned Check: A service charge of $35 will be charged for each returned check
- Expert Testimony & Court Proceeding: The cost of providing Expert Witness testimony or other testimony as may be required is $175.00 per hour, and $75.00 per hour Travel Time
- Immigration Assessments: Complete assessment and written report is $125.00 after a minimum of two office visits at the Private Rate or utilizing insurance coverage.
- Psychological Evaluation and Testing: Complete clinical assessment, testing and written report is $475.00
- Substance Abuse Evaluations: Complete clinical assessment, testing and written report is $275.00
- Financial Hardship: The costs of psychotherapy/counseling and evaluations are set at a fair market value however, you are encouraged to discuss with Bill Mory if you believe you have a current and actual financial hardship and need to make a special arrangement.

Payment & Financial Responsibility: Payment is due at time of service and may be made via cash, money order, personal check or credit card. A service charge of $35 will be charged for any/each returned check. In the event that you are utilizing insurance or employee assistance plans MoryTherapy will assist in the verification of your benefits but may be misinformed by the provider regarding the exact details of your policy. As such, you are responsible to understand the terms of your own coverage and any related limitations. By signing this agreement below, you agree to accept financial responsibility for all services received by Bill Mory and MoryTherapy whether or not paid by insurance.

CLIENT AGREEMENT AND INFORMED CONSENT FOR SERVICES

Client Acknowledgement

By my signature below, I confirm that I have read all the pages of the **Client Agreement and Informed Consent for Services** and that I agree with such terms and that any questions I may have had were answered to my satisfaction. I understand I may request additional copies at any time verbally or in writing to Bill Mory, EdS, LPC, LMFT.

By my signature below, I confirm that I have read all the pages of the Notice of Privacy Practices, called **Your Information, Your Rights, Our Responsibilities** which is enclosed in the same packet of information and that I agree with such terms and that any questions I may have had were answered to my satisfaction. I understand I may request additional copies at any time verbally or in writing to Bill Mory, EdS, LPC, LMFT.

I confirm that I am aware of the plan benefits and requirements of my healthcare insurance plan and/or my employee assistance plan including information regarding co-insurance, co-pays, deductibles, pre-authorizations and physician referrals. I understand that as the client, I am ultimately responsible for all charges incurred including those that may be denied for any reason by my insurance carrier.

My signature below confirms consent to treatment for myself, OR if the client is a minor child, his/ her name is printed below with my signature confirming that I am the Legal Guardian or Managing Conservator, and that I give consent to treatment.

_____	_____	_____
CLIENT SIGNATURE	PRINTED NAME	DATE
_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE

CONSENT FOR DISCLOSURE OF BEHAVIORAL HEALTH TREATMENT INFORMATION

I, _____ (PRINTED NAME OF CLIENT OR GUARDIAN**)** hereby request and authorize William (Bill) Mory, Ed.S., MoryTherapy and representatives thereof, to disclose to and/or obtain from the person or agency listed below information about _____ (PRINTED NAME OF CLIENT).

Information and records may be disclosed to and with the follow person or agency:

_____.
Person or agency with whom information and records may be shared)

CHECK and INITIAL all items below that may be disclosed. Items NOT CHECKED AND INITIALED will not be disclosed.

☐ Assessment Information and Diagnosis	Initials: _____	☐ Discharge Summary	Initials: _____
☐ Summary of Treatment and Progress	Initials: _____	☐ Intake and Demographic Information	Initials: _____
☐ Current Treatment Update	Initials: _____	☐ Financial, Health Insurance, Billing Records	Initials: _____
☐ Dates of Counseling Visits	Initials: _____	☐ Psychological Evaluation	Initials: _____
☐ Medical Information	Initials: _____	☐ Other:	Initials: _____

REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to William (Bill) Mory, EdS, LPC, LMFT at 219 South Travis, Sherman, TX 75090. I further understand that a revocation of the authorization is not effective related to action that has been taken prior to receipt of the revocation.

EXPIRATION: I confirm that this consent, unless cancelled earlier in the manner described above, shall expire on _____ (Date) at _____ (Time) with or without any express written revocation.

CONDITIONS: I further understand that William (Bill) Mory, EdS, LPC, LMFT will not condition my treatment on whether I give authorization for the requested disclosure.

FORM OF DISCLOSURE: Unless specifically requested in writing that the disclosure be made in a certain format, William (Bill) Mory, EdS, LPC, LMFT reserves the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

CLIENT ACKNOWLEDGEMENT: I hereby release the above listed parties and their representatives from all legal responsibility that may arise from any disclosure made pursuant to this authorization and consent. This release shall be made in compliance with Federal Regulations 42 CFR Part 2, Section 33 of PL 91-616 as amended by PL 93-282 and with all applicable state and local laws. This consent to disclose may be revoked by the undersigned at any time by submitting a written statement of revocation specifically referencing this consent to disclose. Such revocation shall be honored except in cases where information may have already been released.

_____	_____	_____
CLIENT SIGNATURE	PRINTED NAME	DATE
_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE