Ken Bateman
Kenneth V. Bateman, PLLC

1901 N. Central Expwy. Suite 220
Richardson, TX 75080
972-680-8986 EXT. 300 OFFICE
972-680-9216 FAX
ken@drkenbateman.com

PATIENT INFORMATION & CONSENT TO TREATMENT

PATIENT INFORMATION

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: Date:
Home address City/State/Zip:
Email Address: Date of birth:
Phone: Home: Mobile: ( ) -
Age:

Single ☐ Married ☐ Divorced ☐ Separated ☐ Cohabitating ☐ Widowed ☐

Gender: ☐ Male ☐ Female ☐ Other _____

Employed by: Occupation:
Spouse / Partner: No. of years together:
Spouse / Partner's Email: Occupation:
Emergency contact name: Contact's #: ( ) -
Relationship to Client:

Please Indicate Type (s) of Counseling In Which You Are Interested:

Individual ☐ **Marital** ☐ **Relational** ☐ **Family** ☐ **Neurofeedback** ☐ **Other** _____

CHILD OR ADOLESCENT – If Patient is NOT a Child or Adolescent skip to "Other persons...living..."

Name of Client: Age: ___ M ☐ F ☐
(If child or adolescent)
School name: Grade: __ Date of Birth: _____

Are the parents of the Client divorced? Yes ☐ No ☐ **If yes:** According to the divorce decree, who is allowed to seek treatment on Client's behalf**?**

Only Mother ☐ Only Father ☐ Either Parent ☐ Other: _____

****Please note a copy of the divorce decree declaring guardianship MUST be on file before the child or adolescent can be seen****

Any children not living in your home:

Name	Age	Gender

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Other persons currently living in your home not previously listed:

Name	Age	Gender	Relationship

FINANCIALLY RESPONSIBLE PARTY

Name: ______________________ Relationship to client: ______________________

Address: ______________________ Home Phone: ( ) - ______________________

City/State/Zip: ______________________ Bus. Phone: ( ) - ext. ______________________

Employed by: Email:

Private Pay: Yes ☐ No ☐

How did you find us? (Please check one and be specific)

Friend ☐ Psychology Today ☐ Dr. referral ☐ Web site ☐ Internet search ☐

Name of referral: Other:

Source:

Reason for referral: ______________________

MEDICAL INFORMATION

Have you previously received any type of mental health services (counselors, therapist, psychiatric services, etc) in the past two years?

☐ No

☐ Yes, previous therapist/counselor (optional): _____ Phone : ( ) - ext.

Issues of concern: ______________________

____

Reason for termination of counseling: ______________________

Are you currently seeing any other mental health professional (Psychiatrist/Marriage & Family Therapist/Social Worker/Licensed Professional Counselor/ Other)?

☐ No

☐ Yes

Are you currently taking any prescription medication?

☐ No ☐ Yes, If Yes, Please list:

Medication:	Prescribed for:	Prescribing Physician:

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Please list any inpatient treatment you may have received:

Name of primary physician: Phone Number: ( ) - ext.

Name of psychiatrist (if applicable): Phone Number: ( ) - ext.

Any history of depression, anxiety, substance abuse, mental illness, etc. in the family? Yes ☐ No ☐

If yes, please explain: _____

In your own words, please describe why you are seeking counseling:

GENERAL HEALTH AND MENTAL INFORMATION:

1. How would you rate your current physical health? (please choose one)
   Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

   Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleep habits?

   Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

   Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

   Please list any difficulties you experience with your appetite or eating patterns:

4. Are you currently experiencing overwhelming sadness, grief, or depression?
   ☐ No
   ☐ Yes, - for approximately how long? _____

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5. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   ☐ No
   ☐ Yes, - when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain?
   ☐ No
   ☐ Yes, - please describe: _____

7. In regard to alcohol, I: ☐ Never drink ☐ Consume drinks per week
   ☐ Drink on social occasions ☐ Recovered alcoholic, sober years

8. In regard to drugs, I: ☐ Have never used drugs. ☐ Currently use _____
   ☐ Used to use but quit years ago

9. Are you currently in a romantic relationship? ☐ Yes ☐ No
   If yes, for how long?

10. My Spiritual/Religious preference: _____

11. What significant life changes or stressful events have you experienced recently?

____
____

PSYCHOSOCIAL STRESSORS

Please indicate any issues that you (the Client) are having difficulty with:

☐ Hopelessness
☐ Fatigue
☐ Helplessness
☐ Grief/Loss
☐ Racing heart
☐ Worthlessness
☐ Stress
☐ Divorce/Separation
☐ Lack of enjoyment of life
☐ Parenting issues
☐ Emotional abuse
☐ Hyperactivity
☐ Sadness
☐ Panic Attacks
☐ Poor Appetite
☐ Depression
☐ Weight Issue
☐ Self-control issues
☐ Anger/frustration
☐ Marital issues
☐ Isolation/withdrawal
☐ Eating disorder
☐ Difficulty relaxing
☐ Inferiority Feelings
☐ Job Stress
☐ Thoughts of hurting self
☐ Thoughts of hurting others
☐ Nightmares
☐ Anxiety
☐ Loss of employment
☐ Phobias
☐ Obsessive thoughts/behaviors
☐ Excessive worry

Have you ever considered or attempted suicide? Yes ☐ No ☐

If yes, please explain:
____
____

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ADDITIONAL INFORMATION:

Are you currently employed? Yes ☐ No☐

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in counseling?

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Consent to Treatment

Please read carefully the following information concerning our professional services and business policies and discuss with your therapist any questions you may have. Your therapist will also go over this consent verbally. Please be sure to complete the emergency contact section of the Consent to Treatment. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications:

Ken Bateman, Ed.D., is a Licensed Marriage & Family Therapist Supervisor; a Licensed Professional Counselor Supervisor (LPC); a Board Certified-Telemental Health Provider; and is a *NeurOptimal* Trainer in Neurofeedback.

Ken Bateman, Ed.D., LMFT-S, LPC-S maintains an independent practice at 1901 N Central Expressway, Suite 220, Richardson, Texas 75080 providing a variety of mental health services. Dr. Bateman subleases space and contracts for support services from NDCWC, LLC, dba New Directions Counseling & Wellness Center ("the LLC") and is not in a partnership or any other form of business entity with the LLC or with any of the other mental health providers practicing at this location, all of whom maintain their own independent practices.

Orientation: I have been trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, psychodynamic, and solution-oriented, short-term therapy. I may employ a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. My overall goal in therapy is to assist you in being as healthy as possible, physically, mentally, emotionally, relationally, and spiritually. I believe all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. I am committed to providing quality counseling care to assist you in achieving these goals.

Nature of Counseling Services: The purpose of counseling and relationship counseling treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall wellbeing; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals and working to make changes. I will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. I will do my best to be sensitive to the pacing and timing of these discussions to maximize a therapeutic result. If at any time you feel that we are moving too fast or in a directions that you are not happy with, please let me know.

Therapy Relationship: Sessions are usually 50 to 60 minutes on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While counseling often addresses very personal issues, for your work to be therapeutic, the relationship between you and your therapist must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with your therapist will be limited to sessions you schedule at our office. I will not accept friend requests on social networking sites. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. **Any phone calls lasting more than 10 minutes will be charged per minute at your regular session rate**. For example: if your regular session fee is $100/per a session, a call lasting 15 minutes will be charged $25.00. $100/60 minutes = $1.67. 15 minutes x $1.67 = $25.00. This same pricing structure will be used for email correspondence. For your protection, I advise emails to be limited to dealing with typical office

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matters such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

Effects of Therapy: Counseling can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, I cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, I will anticipate these risks and discuss them with you throughout the course of therapy. I am committed to working with you to achieve the best possible results for you.

Patient Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. I will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with me are crucial to your success in therapy. You have the right to discontinue your professional relationship with your me at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations I might make. If your refusal compromises my ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), I may determine to discontinue treatment. In such cases, I will provide you with referrals to another competent mental health professional, if you desire.

My services will be rendered in a professional manner consistent with the legal and ethical standards established by the Texas State Licensing Board for Marriage and Family Therapists, and the Texas State Licensing Board for Professional Counselors. If at any time or for any reason you are dissatisfied with my services, please let me know. If you are still unsatisfied, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-252-8154.

Referrals: Throughout the course of therapy, your therapist may make recommendations concerning treatment, some of which may involve alternative treatment options we do not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time, you I believe a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment:

Session fees for counseling are $150 per 50-minute session. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. If you wish to pay by personal check or with cash, you may do so, but I will still need a credit card number on file to bill for no show or late cancellations. If payment becomes a hardship for you, please discuss this with me so a suitable payment plan can be arranged for you. Doctor Bateman does not accept insurance at this time.

Other services for which additional fees may apply include: telephone calls, clinical consultations with other providers that you give consent or request me to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

For legal proceedings that require Dr. Bateman's response, will be billed at $400 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). The court fee will be billed at the stated amount with a **4-hour minimum** charge. Payment is due and is **non-refundable 48 hours in advance**. Any additional time spent on the day of court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectation of payment. You are responsible for **ANY legal**

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fees that your therapist incurs related to your case or treatment (including, but not limited to, any legal consultation that is sought regarding your case or treatment). I reserve the right to suspend services if there is an unpaid balance in your account. With regard to litigation, please note that a Licensed Professional Counselor (LPC), and Licensed Marriage and Family Therapist (LMFT) are not considered an expert witness in the courts. LPCs and LMFT's are considered a "witness of fact" in the state of Texas. Any testimony given by LPCs or LMFT's in court will be allowed only as a "witness of fact". **Payment will be expected from you, regardless of whose attorney subpoenas my involvement**. Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Cancellation Policy: If you are unable to keep a scheduled appointment or need to change an appointment, please notify my office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled at your regular session rate.

Records and Confidentiality: All records may legally be disposed of after seven years for an adult, and 6 years beyond the age of majority for a client under the age of 18, after the file is closed.

Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your **protected health information,** recorded in your patient file, which will remain confidential and stored securely. The personnel in our office who may need to access your file for administrative purposes are also bound by confidentiality. When disclosure of your records is required by law, you will be notified. These provisions are described to you in the **notice of privacy practices** on pages 10-12 of this file.

You should be aware of the following **Exceptions to Confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name:	Phone Number:	Relationship to Patient:
	( ) - ext.	
	( ) - ext.	

Couples/Family Therapy: When seeing couples or families, I will treat as confidential (within the limits cited above) information you disclose that you specifically request not be shared with your partner or family member. However, open communication is encouraged between couples and families, and I may reserve the right to terminate treatment if I judge a secret to be detrimental to the therapeutic process.

You should be aware that some insurance plans do not cover marital and/or family therapy.

Phone Messages, Fax Transmissions, and Email:

HIPPA regulations and our professional Code of Ethics both require that we keep your Protected Health Information private and secure, and indeed I want to do so. I always prefer to have communication via a phone call. Email and texting are very convenient ways to handle administrative issues, but neither is 100% secure. Some of the potential risks you might encounter if we e-mail or text include:

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- Misdelivery of email to an incorrectly typed address.
- Email accounts can be "hacked", giving a 3rd party access to email content and addresses.
- Email providers (i.e. Gmail, Comcast, Yahoo) keep a copy of each email on their servers, where it might be accessible to others.
- Our phone might be visible to others who could see a text message.
- If a phone is stolen the security might be breached, making text messages accessible by others.
- Text messages can be accessed online by the account holder. If you are not the primary account holder this may mean a family member can access your messages.

For these reasons, I prefer to not use email or text to discuss clinical issues (i.e. the important things that need to be talked about in session.)

If you are not comfortable with these risks, administrative issues will be managed via phone calls.

I ☐ DO ☐ DO NOT

consent to use electronic communication for administrative matters. If given, consent will expire 1year after our last appointment. This means that we will not initiate contact via email or text, but that we will briefly reply if you do.

Please initial the following that apply:

I authorize messages may be left for me regarding appointments or returned calls. (**Initial <u>All</u> that apply**)
___ My home answering machine ___ With a family member ____My cell phone ___My work voicemail
___Text messaging ___ Email
___ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.
___ Emails may be checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

<u>Transfer of Records</u>: In the case of my death or incapacity, the therapists in this office have made provision for another mental health provider to take possession of all patient records. In this event, you may contact Cynthia Swanson (witindustries@att.net), or Frank Geis, M.A., LMFT, for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

I hereby give my consent for counseling treatment from the therapist signed below. I have read this document carefully and understand the information regarding consent and New Directions Counseling and Wellness Center services and policies contained herein. Any questions I had were discussed and answered to my satisfaction. I agree to comply with the policies stated. I understand that, should I require services when my therapist is on vacation, this consent is transferable to the covering professional as designated by my therapist. I have been furnished a copy of this statement.

Patient Signature: Date:

Parent/Legal Guardian: Date:
(If patient is under age 18)

Therapist: Date: (Fill in Please)
Dr. Kenneth V. Bateman

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed
and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with New Directions Counseling. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

New Directions Counseling & Education Center is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices -
We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your counselor or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases, we may deny your request. If a denial is made, you will receive a written notice as to the reason for withholding the information

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If a denial is made, you will receive a written notice as to the reason for withholding the information

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How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities.
Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

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Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints

NOTICE TO CLIENTS The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Please call 1-800-821-3205 for more information.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

Signature of client, or in the case of a minor, their legal guardian	Date
Printed name of client	

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Consent for TeleMental Health Counseling

1. **Therapist's Qualifications**: Dr. Ken Bateman, is a Licensed Marriage and Family Therapist, a Licensed Professional Counselor, and a Board Certified-TeleMental Health Provider who offers clients the option of doing counseling sessions online or in the office.

2. **Purpose**: TeleMental Health Counseling involves the use of audio, video or other electronic communications to Interact with you for the purpose of doing psychotherapy.

3. **Benefits, Risks, and Alternatives**: The Benefits of TeleMental Health Counseling include having access to your therapist without having to travel outside of your community. A potential risk of TeleMental Health Counseling is that there may be an interruption of services due to technical problems, within or beyond your or the therapist's control. Doing an in-office appointment with Dr. Bateman, or referral for a face-to-face session with another therapist in your area is always an option. TeleMental Health Counseling, while an accepted form of therapy, does not work for everyone. You and your therapist will determine if this delivery method is the best for you at this time.

4. **Confidentiality**: Confidentiality will be observed by the therapist. No recordings, without your consent, will be made of any sessions. Dr. Bateman does TeleMental Health Counseling thru Zoom, a HIPAA compliant platform. Notes of your session will be protected in the same manner as "in-office" sessions.

5. **Rights**. You may withhold or withdraw consent to TeleMental Health Counseling at any time before and/or during the sessions without affecting your right to future sessions with this therapist or referral to another professional.

6. **Questions**: You have the right to discuss this information with your therapist and to receive answers to your questions before or after signing this consent.

I have read the information provided above. I have had an opportunity to ask questions about this information and all my questions have been answered. I have read and agreed to a TeleMental Health Counseling session.

_____ _____
Electronic Signature of Client (Parent or Guardian) **Date**

_____ _____
Electronic Signature of Client **Date**

_____ _____
Electronic Signature of Client **Date**

Dr. Kenneth V. Bateman **Please fill in date below:**

Electronic Signature of Therapist **Date**

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972-680-8986 EXT. 300 OFFICE
972-680-9216 FAX
ken@drkenbateman.com

TELEMENTAL HEALTH COUNSELING SAFETY PLAN

CLIENT NAME:

ADDRESS:

CITY: **COUNTY:** **STATE:** **ZIP:**

Client's Phone #: **Alternative Phone #:**

First Emergency Contact: Relationship:

Phone Number: City/State:

Second Emergency Contact: Relationship:

Phone Number: City/State:

Local Hospital (related to location of client):

Phone Number:

- I have provided two emergency contact numbers and the local hospital or other appropriate facility.
- If the therapist determines that there is a need, my therapist has permission to contact my emergency contacts, local authorities, or hospital.
- I have provided a working telephone number in case the telehealth counseling session fails during a session.
- My therapist has given me a contact number in case the telehealth counseling session fails during a session. If my therapist does not call me back within 5 minutes, then I will call my therapist.

SIGNATURES:

Electronic Client Signature Date

Electronic Client Signature Date

Dr. Kenneth V. Bateman **Please fill in date below:**

Electronic Signature of Therapist **Date**

Ken Bateman
Kenneth V. Bateman, PLLC

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Credit Card Authorization of Payment

Your therapy minutes are important to us! Instead of taking time from your session to process payment, we ask our clients to fill out this credit card authorization form. Your card will be billed for each session at the end of the business day and a receipt for payment will be emailed to you. Please note that any missed appointments or late cancellations will be billed to this card.

I authorize Kenneth V. Bateman, PLLC to charge the credit card ending in
for payment of my counseling sessions. I understand my card will not be charged for any other services or products without m prior consent. Missed or cancelled appointment fees with less than 25 hours notice may be charged.

Electronic Signature Date

After the credit card information provide has been entered into our secure payment software the information below will be detached and shredded. Thank you for your authorization.

NAME AS IT APPEARS ON CARD:

TYPE OF CARD:

CREDIT CARD NUMBER:

EXPIRATION DATE:

SECURITY CODE (3 DIGITS; 4 IF USING AMEX)

ZIP CODE:

E-MAIL ADDRESS TO SEND RECEIPTS:

CC - E-MAIL ADDRESS TO SEND RECEIPTS IF DESIRED: