Iris Psychological Services, PLLC
Lisa D. Hensley, Ph.D.

Office, Financial, and Privacy Policies and Consent for Assessment/Treatment

1. My fee is $150.00 per 50-minute appointment. For a small number of clients, I am able to offer a sliding scale for my fees based upon income. If this is available, I will let you know, and your fee will be changed on this form.

2. Fees are due at the time of service. I am currently in-network for Blue Cross/Blue Shield, Cigna, and Humana. I will file insurance benefits for these insurance carriers. If you have insurance with a different carrier, I do not file for insurance benefits, but I am happy to provide you with an invoice so that you may file for reimbursement with your insurance company if you wish. I cannot guarantee that your insurance company will reimburse you, however. Please note that for you to file for insurance reimbursement, I will need to disclose information about mental health diagnoses (if applicable) and the nature of the treatment being provided.

3. If you are unable to keep an appointment, please call the office at least 24 hours prior to the appointment if at all possible. This will allow me time to schedule another client in this time slot. If you do not arrive for the appointment and do not call prior to the appointment, you may be charged a "no-show" fee of $50. If you do file for insurance reimbursement, please be aware that your insurance company will not pay for no-shows.

4. Please be aware that I am likely to be unavailable in an after-hours emergency. I do not have an office receptionist or an after-hours answering service. If you are in crisis, please call 911 or go to your nearest hospital emergency room. Please also contact my office, and I will return your call as soon as I am able.

5. Any information that you share with me is considered Protected Health Information, and as such is covered by HIPAA regulations. I will go over this information with you in a separate handout. Please understand that I am legally required to break confidentiality and disclose information to appropriate parties under the following circumstances:

a. Imminent danger to you or to someone else;
b. Child abuse or elder abuse where there is an ongoing threat to you or someone else;
c. if I am required to disclose information by a court order from a judge.

I have read and understood my rights and the policies of Iris Psychological Services. I have also reviewed my HIPAA privacy rights and have been provided a copy of this notice as well as a HIPAA brochure if I requested them. I voluntarily consent to assessment and/or psychotherapy by Dr. Hensley.

Signature Date

Iris Psychological Services, PLLC
Lisa D. Hensley, Ph.D.
1201 N. Watson Rd., Suite 117
Arlington, TX 76006
(817) 962-0035

Client Information Form

Your complete name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Daytime number: _____

Email address: _____

Age: _____ Birthdate: _____ Birthplace: _____

Education (grade completed, any postsecondary): _____

Current Occupation: _____

Person to alert in the event of medical emergency: _____

_____

Relationship to you: _____ Phone: _____

Family Doctor: _____ Phone: _____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Names of people who are significant in your life and you're likely to bring up in therapy, and their relationship to you (e.g., partners, children):

_____
_____
_____
_____

Please describe any significant current or past medical problems.

_____
_____
_____
_____

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

_____
_____
_____

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

_____

_____

_____

_____

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please give the dates and the nature of the difficulty at the time: _____

_____

_____

In your own words, what is the nature of the concern that you wish to address in therapy?

_____

_____

_____

_____

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Consent to Be Contacted

Please mark an X next to the choice(s) that describe your wishes about my contacting you to remind you of an upcoming appointment, to cancel an appointment with you (which would only happen in case of emergency), or to obtain other information necessary for treatment.

_____ Dr. Hensley or her staff may contact me through the email address provided on my client information form.

_____ Dr. Hensley or her staff may contact me via the daytime telephone number provided on my client information form.

My preferred method of communication is: _____ telephone

_____ email

_____ I do not wish to be contacted for appointment reminders or emergency cancellations. I understand that this may result in my failing to be informed about emergency changes in Dr. Hensley's schedule.

_____

Signature of Client Date

Iris Psychological Services
1201 N. Watson Rd., Suite 117
Arlington, TX 76006
(817) 962-0035
drhensley@irispsychologicalservies.com

CONSENT TO RELEASE INFORMATION FOR THIRD-PARTY PAYMENT

I, _____ , hereby consent to Dr. Lisa Hensley/Iris Psychological Services releasing treatment information as necessary to secure payment from a third party (e.g., an insurance company), including dates of service, type(s) of service(s) provided, diagnosis and/or other treatment information. I understand that once this information is released to a third party, that Iris Psychological Services and Dr. Hensley cannot control how that information is used. I understand that Dr. Hensley will collect any applicable co-payments from me at time of service. I further understand that I will be billed and will be financially responsible for any fees that are not paid by the third party.

_____

Client (or representative) Date

Client: _____
Client DOB: _____
Policy Owner Name: _____
Policy Owner DOB: _____
Address:

_____

_____

Phone:

_____

Employer: _____
Ins Co:_____
Policy# _____
Group # _____
CoPay/Co-Insurance: _____