**Ramsey Khasho, Psy.D.**
Family Psychiatry of The Woodlands
8701 New Trails Drive, Suite 150, The Woodlands, Texas 77381
Phone: 281-367-1015 Fax: 281-367-1966

## New Patient Information

Patient Name: _____ Today's Date: _____
Date of Birth: _____ [ ] Male [ ] Female
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Employer: _____

## Insurance Policy Holder Information

Name: _____ Relationship to Patient: _____
Date of Birth: _____ Social Security #: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Employer: _____
Insurance Company: _____ Insurance Phone: _____
Group #: _____ Policy #: _____

**A copy of your driver's license and insurance card is needed.**
**Payment of services is handled prior to your session**

All reasonable requests for confidential handling of your health care information by alternative means will be granted:

- May we leave a message on your home answering machine? [ ] Yes [ ] No
- May we leave a message on your work answering machine? [ ] Yes [ ] No
- May we leave a message on your cell phone? [ ] Yes [ ] No
- Do you have an alternate phone number we may use? [ ] Yes [ ] No
  If yes, phone number is: _____
- May we share information regarding appointments or billing inquiries only with your spouse or immediate family member? [ ] Yes [ ] No
- Emergency Contact Name & Phone #: _____
- If the patient is a minor (17 years of age and under), biological parents are: [ ] Married [ ] Never Married [ ] Divorced

Please complete the following section ONLY if you want communications regarding your health care information or billing sent to an **alternate address other than your residence:**

Address:_____City:_____State:___Zip:_____

**Ramsey Khasho, Psy.D.**
Clinical Psychologist . Texas License 34084

Family Psychiatry of The Woodlands
8701 New Trails Drive, Suite 150
The Woodlands, Texas 77381
Phone: 281-367-1015 . Fax: 281-367-1966

# OUTPATIENT PSYCHOLOGICAL SERVICES AND POLICIES CONTRACT

This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have in order to discuss them during our initial session. Your clear understanding of outpatient psychological services and policies is very important. When you sign this document, it will represent an agreement between us and all patients must complete this form before services can be rendered.

## OUTPATIENT PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular issues that you may bring forward. There are many different methods I may use to deal with the issues that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on matters we discuss during our session and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for individuals who experience the process. Psychotherapy can lead to better relationships, significant reductions in feelings of distress, personal growth and fulfillment, and identifying possible solutions to problems. There are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. At the end of the evaluation, I will be able to offer you some impressions of what our work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your opinions of whether you feel comfortable working with me. Therapy involves a significant commitment of time, money, and energy, so you should be careful and comfortable with the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional.

In the event of a divorce, I must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has managing conservatory privileges for the minor child.

## SESSIONS

I usually utilize our initial two sessions to conduct an assessment. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. I will usually schedule one 50-minute session (one appointment hour of 50

minutes duration) per week at a time we agree on. Longer or more frequent sessions can be arranged.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

## PROFESSIONAL FEES

My hourly (50-minute session) fee is $150. **Payment of Services is handled prior to your session.** A personal check, cash, or credit card (Visa, MasterCard, Discover, American Express, and Debit) are acceptable methods of payment. If a check is returned for insufficient funds, I will not accept another check from the patient. Payment will have to be cash, credit, or debit. There is a $25 returned check fee. I do not accept temporary or post dated check if you are a new patient.

Our therapeutic relationship may also require me to gather or exchange information with you or others with your consent. Any services beyond the psychotherapy hour with a duration greater than 5-minutes will be charged at the prorated rate of $150 per hour.

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many confidential matters, it is agreed that should there be a legal proceeding neither you nor your attorney/s, nor anyone else acting on your behalf will call me to testify in court or at any proceeding, nor will a disclosure of psychotherapy records be requested. The only exception to this is if I have agreed to complete a court-ordered evaluation.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. I charge **$200 per hour** for preparation and attendance at any legal proceeding because of the level of involvedness required.

## REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies that I am contracted with. In order to achieve this, we must have all current insurance information on file.

**If there are any changes in your insurance coverage, you must notify our business office 5 days prior to your next appointment or the visit will be self pay or rescheduled.**

If I am an in-network provider for your insurance company, our office will file for you. Insurance must be verified prior to your visit by calling 281-367-1015 or faxing our office at 281-367-1966. Your insurance company mandates that you pay your co-payment at the time of service. You will be responsible for your deductible. Should your insurance company not pay your claims, your balance is your financial responsibility. If I am not in your insurance network, you may request to be provided with a receipt that you may file with your insurance company.

You must stay current with the payment of your deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is an estimate only. You are ultimately responsible for any and all balances on your account.

Please note that if insurance is being used, they require that I diagnose your mental health condition before they will reimburse you for my services. I will discuss with you the diagnosis I plan to render, if you wish, before you file claims with your insurance company. Any diagnosis made will become part of your permanent health record.

If your account has not been paid for more than sixty (60) days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services provided, and the amount due.

**Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our Business Office Staff. Contact our billing office at 281-363-4693**

## APPOINTMENT CANCELLATIONS

Appointments can be scheduled and cancelled by calling 281-367-1015. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24 hours advanced notice** of cancellation. **With less than 24 hour notice, you will be billed $150 per hour scheduled.** Please do not rely on appointment reminder calls, as this is a courtesy. If you feel that you were charged in error, please discuss the matter with our office manager.

## TELEPHONE AVAILABILITY AND EMERGENCIES

I can be reached by telephone at 281-367-1015. I am often not immediately available by telephone. When I am unavailable, you may leave me a voicemail message that I frequently monitor. I will make every effort to return your call on the same day you make it, with the exceptions of weekends and holidays. I am not available for telephone contact before 9:00 am or after 6:00 pm. Leave a voicemail message indicating your name nature of the call, and telephone number in order to reach you. Occasionally, technology malfunctions and your first call may not have registered for one reason or another. Please do not hesitate to call again and leave a second message.

If you are unable to reach me and you are experiencing a life-threatening emergency, call 911 immediately or go to your nearest hospital emergency room. Additionally, there is a 24-hour paging system for emergency situations. There is a $45.00 charge for non-emergent after hour's calls.

## ABSENCES

There are times during the year when I will be away for several days or weeks for professional meetings, trial testimony, vacations, etc. Usually these absences are quite predictable, and in

general, advanced notice will be given. If you would like to consult with someone else during the time that I am unavailable, I can provide you with the name of a therapist. With your signed consent, I will brief the substitute therapist on various relevant treatment issues in advance, and will follow-up with the substitute therapist upon my return. Occasionally, in the case of forensic work or illness, much shorter notice may be given for an absence; however you will be advised of this possibility as soon in advance as possible.

## UNTIMELY INTERRUPTIONS TO TREATMENT

Consistent with the professional code of ethics, I am required to plan for an unpredictable interruption in treatment due to potential incapacitation. Hence, you may wish to know, that in the event of an unpredictable chronic illness/injury or my untimely demise, you may contact the following mental health professional for a consultation or referral:

David Parmer, MA, LPC, LCDC, Family Psychiatry of The Woodlands
4840 West Panther Creek Drive, Suite 207 The Woodlands, Texas 77381
Phone: 281-367-1015 Fax: 281-367-1966

He possesses release of information forms that would allow him to access your psychological records (if you wish and with your signed consent) so as to assist in providing you with care or referring you to a therapist of your choice. Please feel free to discuss this with me during the course of your consultation if you have any questions.

## PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents.

## CONFIDENTIALITY

Although mental health professionals must always honor your privacy by maintaining confidentiality about your disclosures and securely preserving your records, there are exceptions to this rule. The following is a list of some of the exceptions to confidentiality and privilege for health care providers. I may, or must, break confidentiality and take other appropriate actions as warranted if:

- You disclose child abuse, child sexual assault/exploitation, elder/dependent abuse
- You sign a release of information authorizing me to obtain and exchange information with outside individual/agencies relevant to treatment
- You are a danger to yourself and threaten to harm yourself (i.e. suicidal)
- You threaten to harm another specific person (i.e. assault, kill)
- You disclose a sexual relationship with a mental health professional
- You are being evaluated for Court purposes (i.e. competence, sanity)
- You seek psychological services to enable someone to commit a crime or to avoid apprehension yourself
- You file a lawsuit against me, or anyone else and you are claiming emotional damages

- You accrue a debt and refuse to pay for psychotherapy
- I am compelled by a court order or valid subpoena
- If you are filing information with your insurance company, they may require disclousure of some details to pay for counseling sessions
- At Family Psychiatry of The Woodlands, we work as a team. Thus, one professional staff member may periodically consult with other qualified professional staff members to ensure that we are delivering the highest quality services to our patients. All of our staff are bound by the same requirements for confidentiality

I, _____, hereby make request for myself, or my minor child, _____to receive care and treatment voluntarily from Ramsey Khasho, Psy.D. I understand that such care and treatment may consist of an evaluation process, therapy, assessment, and/or case management.

Ramsey Khasho, Psy.D. is hereby authorized to provide treatment/services described above if this request is accepted. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against the advice of my therapist at any time. I also have the right to request a change of clinincian without being subjected to discrimination or any penalty.

**I have read and understood the information in this document, Outpatient Psychological Services and Policies Contract, and agree to accept treatment/assessment for myself/my child, and I further agree to abide by its terms.**

_____ _____
Patient Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

**I hereby authorize my insurance carrier to pay for benefits directly to Ramsey Khasho, Psy. D. or Family Psychiatry of The Woodlands, P.A. for services provided to myself or my insured dependents. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to Ramsey Khasho, Psy.D. or Family Psychiatry of The Woodlands, P.A.**

_____ _____
Parent/Guardian Date

**Ramsey Khasho, Psy. D.**
Family Psychiatry of The Woodlands
8701 New Trails Drive, Suite 150, The Woodlands, Texas 77381
Phone: 281-367-1015 . Fax: 281-367-1966

**Authorization for Release/Exchange of Confidential/Medical Information**

Date_____ Medical Record #: _____

_____/_____ is currently receiving services with Dr. Khasho
(Name of Patient) (Date of Birth)

I hereby give permission for an exchange of information/records between:

Ramsey Khasho, Psy.D., Clinical Psychologist, Texas License #34084
Family Psychiatry of The Woodlands
4840 West Panther Creek Drive, Suite 210, The Woodlands, Texas 77381
Phone: 281-367-1015 . Fax: 281-367-1966

**AND** (list name/s and contact information)

This exchange of information will include all relevant information needed for evaluation, assessment, diagnosis, and treatment.

This consent is subject to written revocation by the undersigned at anytime unless action has already been taken in reliance of said consent. This consent expires one year from date signed, unless earlier revoked.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

## Notice of Health Information Privacy Practices

## Acknowledgement of Receipt

I have received and read the Notice of Health Information Privacy Practices and understand my rights contained in this notice.

_____ _____

Print Name Date

_____ _____

Signature

_____

Minor Patient First and Last Name

**Ramsey Khasho, Psy. D.**
**Family Psychiatry of The Woodlands, P.A.**
**8701 New Trails Drive #150**
**The Woodlands, Texas 77381**

## Clients' Rights

1. **You have all the rights of any other resident of the State of Texas and the United States of America.**
2. You have the right to not be discriminated based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
3. **You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.**
4. You have the right to be free from abuse, neglect, and exploitation.
5. **You have the right to be treated with dignity and respect.**
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
7. **You have the right to accept or refuse treatment after receiving this explanation.**
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
9. **You have the right to know the qualifications of the staff responsible for your treatment.**
10. You have the right to refuse to take part in research without affecting your regular care.
11. **You have the right not to be given medication you don't need, or too much medication.**
12. You have the right to have information about you kept private and to be told about the times when the information can be released without you permission.
13. **Unless otherwise provided by law, you have the right to withdraw at any time you permission for something you agreed to earlier.**
14. You have the right to make a compliant and receive a fair response from this facility within a reasonable amount of time.
15. **You have the right to contact and consult with counsel at your expense.**
16. You have the right to select practitioners of your choice at your expense.
17. **You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.**

**I acknowledge having read and understood the above client rights.**

| | |
|---|---|
| _____ | _____ |
| **Signature of Patient** | **Date** |
| _____ | _____ |
| **Signature of Parent or Legal Representative** | **Date** |
| _____ | _____ |
| **Signature of Witness** | **Date** |

**Patient Guidelines and Consent for Use of E-mail Communications**
**Family Psychiatry of The Woodlands**

To better serve our patients, this office has established a website for some forms of communication. Our website will allow you to send messages to the appropriate staff member in regards to scheduling, practitioner questions, billing issues, and medication refills. Please remember, however, that this form of communication is **not appropriate for use in an emergency.** The turnaround time for routine patient communications is within twenty-four hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Types of communication that are appropriate for e-mail include:

- scheduling inquiries
- non-urgent medical advice
- billing or insurance questions
- test and lab results
- home health monitoring reports
- prescription refill requests (per practice policy)
- educational materials

When sending e-mail, please put the subject of your message in the subject line so we can process it more efficiently. Some forms of communication (e.g., HIV, mental health, work-related injuries and disability) are not appropriate for e-mail. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the auto reply feature.

*Communications relating to diagnosis and treatment will be filed in your medical record.*

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

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**I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.**

**I understand and agree to the above e-mail policy.**

_____
Patient signature

_____
Date

_____
Witness (optional)