Susan J. Bramlette, LMFT 10/01/23-24

1751 River Run. Suite 200
Fort Worth, TX 76107

Phone: (512) 356-9238
Fax: (512) 233-1021

http://www.susanbramlette.com email: susanbramlette@susanbramlette.com

Welcome! Thank you for choosing us to address your healthcare needs. Initiating therapy, you may have many questions. P**lease ask questions freely** about policies, state and insurance laws, referrals, and your private healthcare information rights.
Feel free to **discuss any questions** regarding your care at any time **directly in session, or by phone (during business hours M-F 10 a.m. – 8 p.m.)**

A. Registration: Please check the box next to the service you are seeking:

__**Couple's Therapy:** Each partner fills out/signs one form, medical information sheet.
__**Minor Client/Parent:** Parent or Guardian fills out form for youth with Insured's Info.
__**Individual Therapy:** Fill out and sign all parts of the form that apply to you.

Date: _____

Client Name: _____

Date of Birth: _____Age: _____Social Security Number: _____

Address: _____ City/State: _____Zip: _____

Others in Client's Residence:

Phone number(s) we may reach you at:

(_____) _____-_____home/work/cell

(_____) _____ - _____ home/work/cell

Email address: _____

Marital Status (circle): Single / Married / Divorced / Widowed / Other: _____

***B. Insured or Responsible Party's Name**:* _____

Insured's SSN:_____. Insured's Address is same as listed above, or:

Insured's Address: _____ City: _____ Zip: _____

Insured's Date of Birth: _____ Age: _____ Marital Status: _____

Payment by (circle one): Self-pay /Employee Assistance Plan (EAP) /MH Insurance

Insurance Co. Name: _____Mental Health Phone No: _____

Insurance ID No: _____) Group No: _____

Authorization #_____Authorization Set up in Name of: _____

Other Arrangements:

_____

Please note: We have **confidential, secure, iPlum voicemail.** Clients choosing to communicate via email (susanbramlette@susanbramlette.com) or text (512.356.9238) will do so in encrypted Hushmail, signing in with their current email password. Email should be used for scheduling purposes and include minimal clinical information.

Medical concerns -- Please check all individual items that concern you:

___Nerves
___Shyness
___Drug abuse
___Anger
___Stress
___Headaches
___Memory
___Loneliness
___Education
___Temper
___Bowel problems
___ Depression
___Suicidal thoughts
___Alcohol use
___Sleep
___Work tiredness
___Ambition
___Inferiority feelings
___Career choices
___Dream thoughts
___Fear
___Friends
___Self-control
___Relaxation
___Legal matters
___Making decisions
___Concentration
___Health problems
___Appetite/weight
___Stomach problems
___Finances

Please check all relationship items that concern you:

___Closeness
___In-laws
___Communication
___Friendships
___Infidelity
___Recreation
___Partner's cleanliness
___Trusting each other
___Solving problems together
___Sexual desire
___Parenting
___Relatives
___Use of time
___Verbal fighting
___Housing
___Showing appreciation
___Having fun together
___Affection
___Common goals
___Finances
___Jealousy
___Physical fighting
___Agreeing on chores

___Common interests ___Holding other back

Any further relationship concerns not listed above? _____
_____

Mood Scale – Please indicate your general mood level for the last month by drawing a circle around the numbers.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
Suicide ideas Depression Average Good Spirits Joyful

Now, mark an "L" over one of the numbers above to describe the LOW point of your mood during the last year.

Anxiety Scale – Please place an "X" over one of the numbers on the 1 to 10 scale below to indicate your general level of anxiety or nervousness over the last month.

The higher the number, the higher the level of anxiety, nervousness, and tension you are reporting.

1 2 3 4 5 6 7 8 9 10
Peaceful Panicky

Previous therapy experience:
Have you ever been in therapy before? _____Yes/ No If yes, please describe below:

Name of therapist:
_____
What was helpful and **not** helpful about this treatment?
_____
_____

How did you hear about us? (Check one) (Optional)
__ Friend or family member _____ Other:_____
__Internet Search of:_____
__ Professional referral /Yellow Pages/ Brochure /Insurance Panel

Employment
Your Job Title: _____Employer: _____
Partner's Job Title: _____ Employer: _____

C: Professional Disclosure Statement and Policies

We honor your time and *Thank You* for your patience in waiting.
Appointments are generally ***50-60 minutes*** **in length yet can run later as need requires**.
Sessions beginning at ten minutes after will complete on the Hour.

Sessions beginning on the Hour will Complete at ten minutes 'til to allow for copay, appointment-setting and smooth transition.

1. Education: Susan Bramlette earned a master's degree in Marriage and Family Therapy in a joint program of the University of Oregon and Northwest Christian College, Eugene, Oregon, Y2000.

She is licensed by the States of Texas and Oregon and specializes in couples, adolescent, adult, and family therapy. She is a clinical member of the American Association of Marriage and Family Therapists (**AAMFT**.org) and a member of Psi Chi, the American Psychological Association Honor Society. As a licensee, I am required to participate in continuing education on subjects of study related to client needs.

2. Communication: An Open Therapeutic Approach

a. Your counselor practices **Systemic, Bowenian, Intergenerational,** and **Cognitive-Behavioral** Therapy, while other treatment approaches, such as Crisis Management protocol, are also resourced when appropriate. Links on Susan's website provide more information on these modalities. See www.susanbramlette.com.

b. Susan counsels/supports children in family crisis; **She does not participate in custody cases. If you anticipate involvement in a court custody dispute**, **please advise** for a proper referral to a custody evaluation provider.

b. Couples are asked to commit to ten sessions **to support long-term, effective outcomes**. **Between-session assignments** help speed progress toward reaching your goals**. Recommended resource books are listed on the website.**

c. Treatment practices, philosophy, business matters, **or limitations and risks of therapy** may be discussed at any time. ***Your questions are always welcome.***

3. Affiliation: I abide by the Code of Ethics of: the Texas State Board of Examiners of Marriage and Family Therapists/ Mail Code 1982, P.O. Box 149347, Austin, TX 78714 and the Oregon Board of Licensed Professional Counselors and Therapists/ 3218 Pringle Road SE Suite 250 Salem, OR 97302-6312 (503) 378-5499, lpct.board@mhra.oregon.gov Website: www.oregon.gov/OBLPCT, as well as the Code of Ethics of the American Association of Marriage and Family Therapy (AAMFT). Additional information about members and licensees of these is available online.

4. Confidentiality, Notice of Privacy Practices, and Client Rights
Your verbal communication and clinical records are held in strictest confidentiality. We use Hushmail and iPlum encrypted communication. Some exceptions apply by law when:

a) **Billing Staff:** information (date of service, etc.) is shared with our **staff** to expedite your self-pay and insurance billings,
b) Medical Billing: information is shared with your **insurance carrier to process your**

claim,

c) **Abuse:** information provided by you and/or your child/elder discloses the possibility that verbal, **physical or sexual abuse may be occurring,** which by Texas state law I am required to report to the Dept. of Children and Family Services.
d) **Records Request:** you **sign a release of information requesting** that your health care information be shared with a physician, disability insurer, specific other (i.e., your designated emergency contact, below), or,
e) Duty to Warn: you provide information that informs me you may be in **danger of harming yourself or another person,**
f) **Best Practices:** information required for case **consultation with professional colleague,** or,
g) **Subpoena:** when **disclosure is required by law.**
h) **"No Secrets" Policy:** Susan asks those in couple's therapy not to reveal facts they do not wish their partner to know. Secret-keeping is not a contractual agreement in couple's therapy. Partners who prefer to retain secrets from a partner should ask for a referral for individual therapy before entering a season of marital/couple's therapy to ensure this privilege, which is not guaranteed in my couple's work.

As a client of an Oregon licensee, you have the following rights:

∗ To expect that a licensee has met the qualifications of training and experience required by state law;
∗ To examine public records maintained by the Board and to have the Board confirm credentials of a licensee. ∗ To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100);∗ To report complaints to the Board;
∗ To be informed of the cost of professional services before receiving the services;
∗ To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to you or others; 3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me; ∗ To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Please sign:
I/we have read and understand this Notice of Privacy Practices/Client Rights.

---

5. Records Access

a) Records are retained for seven years.
b) Records requests must be **made in writing** with a specific designation of person, address, private healthcare information requested clearly designated. 72-Hour minimum response. A current release of information must be signed and on file.

c) The fee for preparation, copying, mailing of records is listed below.
d) Custodial parents, non-custodial parents, or legal guardians of non-emancipated minor clients have the right to access the client's record **upon written request.**
e) Request for access to stored records may be made from Dr. James Boyer, P.C., LMFT, at 503.224.3522.

6. Emergency Protocol: In an **emergency**, where the client or his/her guardian deems that immediate attention is necessary, **contact the emergency services in the community (911)** immediately. Susan Bramlette will follow emergency services with counseling support to the client and family in a timely manner.
***Please advise as soon as possible at 512.356.9238 after obtaining emergency care.**

a. Emergency Contact (Required): _____
Relationship: _____
Telephone: _____ Email: _____
b. ____(initial) Permission is given to contact the above individual to discuss treatment needs deemed emergency in nature. Other preferences**: _____**

7. Current Prescriptions/Coordination of Treatment with Prescribing Physician/ Current Prescription Medicines in Use: N/A
Previous Prescription Medicines: _____
_____
Prescribing Physician's Name: _____
Current clinic/City: _____ Telephone or fax: _____

If you wish to authorize communication with your primary care physician and/or other treating professional, please indicate below and fill out the **Authorization to Release to Disclose Medical Records** form. Your consent is valid for one year or until such time as consent is revoked in writing.
____Please notify my physician. ____I decline notification of my physician currently.

8. Financial/Insurance Information
Insurance providers with whom we have current contract agreements are:

EAP Consultants/ESPYR	Magellan EAP	Blue Cross/Blue Shield
Empathia EAP /Life Matters	Holman EAP	Wellspring BH
Cigna Behavioral Health	Cigna EAP	PHCS/MultiPlan
Integral Behavioral Health	Magellan	Mines EAP/. AllOne EAP
AETNA	Humana/LifeSync	Interface BH

Please ask concerning other insurances; **single-case agreements** may be available.

Insurance clients: **Please call the number for Behavioral/Mental Health or Employee Assistance (EAP) Services** listed on your insurance card for instructions and provide our billing staff with the following information:

1. Client and Insured's **identification/Group/Authorization number** information.

2. Insurance Company, type (EAP or Mental Health benefit), Date of Authorization Start, Deductible/Deductible satisfied? **Please attach your insurance card prior to session.**

3. Information given by your insurance company about **number of sessions authorized**, **authorization number, co-payment/co-insurance** requirements, as well as the **specific billing address** and **telephone number.**

If you have not satisfied your deductible, insurance rate fee is due at session until met. You may obtain this rate by phoning your insurance carrier at the ph# on back of ins card. My deductible is $_____. It is **satisfied/not satisfied** (circle one).
My copay is: _____. Payment today is: _____.

***Please advise of any changes to your insurance plan or benefits. Thank you!**

9. Fee Schedule for Services Sliding scale available per prior agreement

Intake Appointment (60 minutes):	$140
Individual Appointment, Couples, Family (50-60 minutes):	$120
Group Therapy (90 minutes)	$30
Calls/Letters/Forms/Records Requested by Client in writing	**$60**
Missed Appointment Fee (billed same day via Paypal)	$40
Prepaid Block/ Ten Sessions couples' or individual	$950.

a) __AA **(initial)** As a courtesy we will bill insurance or third-party payor for you, then advise of denied claims, co-insurance required, etc. Please resolve these a.s.a.p. **Accounts receivable over $100 cannot be carried or expanded.**

b) Fees can be paid by telephone cash, check, credit or Debit card, or via Square at www.susanbramlette.com.

c) Copay or Private-Pay session fee is due at the start of session. ***Thank you!***

d) You may choose to put a card on file to cover copays, late cancellations.

e) ____(initial) Client Agreement: If my insurance company denies payment of my claim for any reason, **I accept responsibility for balance due** at the time of Explanation of Benefits ins statement or to **make arrangements for payments.** After 60 days an unpaid balance on my account will be charged 5% invoicing fee a month on balance due.

f) ____(initial) I understand my anticipated fees for therapy and/or I will contact my provider with any questions about fees.

g) ____(initial) Late Cancellation Policy - If I need to **cancel or reschedule** an appointment**, I will give 24 hours advance notice at: 512.356.9238 or pay a $40 missed appointment fee.** Please note: This is a very modest administration fee; your

understanding of the cost of providing multiple services (scheduling, billing, record-keeping) and clinical preparation time is sincerely appreciated.

A copy of this Professional Disclosure Statement is available 24/7 at www.susanbramlette.com.

10. Consent to Treatment: I understand the policies in this statement. I give my permission to begin treatment with Susan Bramlette, LMFT.

Client Signature _____Date: _____

(Signature of parent(s) or guardian for a minor):

_____

acknowledge that I am acting in compliance with my custody agreement and that parent, Name: _____, Relationship: _____, has/does not have, rights to _____'s medical record. Non-custodial parent name_____ phone #_____.x