THE WOODLANDS
BEHAVIORAL HEALTH
& WELLNESS CENTER

Client Information

Today's Date: ____/____/_____ Client Name: _____ DOB: _____/_____/_____

Ethnicity: *American Indian or Alaska Native* ☐ *Asian* ☐ *Black or African American* ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐

Native Hawaiian or other Pacific Islander ☐ *White* ☐ *Other* ☐ *Prefer not to respond* ☐ Gender: *Male* ☐ *Female* ☐ *Other* ☐

Address: _____ City_____ State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Best way to contact? _____

School/Grade: _____ City:_____

Responsible Payor:_____ SSN of Responsible Payor:_____

Emergency Contact

Name: _____Address:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relation to client:_____

Parent(s) / Legal Guardian(s) *-If Minor-*

Are parents divorced? □ No □ Yes If yes, **we will need a copy of your divorce decree.** If divorced parents share custody of the child, **BOTH PARENTS** must sign Consent for Treatment form and Divorce Decree form.

Parent(s)/ guardian(s) name: (if child is a minor) _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Custodial parent or legal guardian name: (if parents are divorced) _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Pharmacy Information

(For sending electronic prescriptions)

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Address:_____Pharmacy Fax:_____

*Please note that not all pharmacies can accept all electronic prescriptions. Please see staff with questions.

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CONSENT FOR TREATMENT

I hereby seek and voluntarily consent to take part in treatment and authorize The Woodlands Behavioral Health & Wellness (TWBHW) to treat _____.

(Client's Name)

I understand that treatment services may include face-to-face contact interviewing and psychological testing, psychopharmacology care, psychotherapy, coaching, nutritional support and/or other services provided by clinicians of TWBHW. Services may also include the clinician's time required for the reading of records, consultations with other clinicians, scoring, interpreting results of testing, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate. _____ **(Please initial here)**

I am aware that the practice of psychotherapy or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this office or treating therapist. I understand that my/my child's clinician(s) will direct treatment based on signs, symptoms, neuropsychological assessments, and any laboratory results. I understand that it is not always possible to give a definitive diagnosis. Further, I understand that evaluation and treatment will involve discussion of personal events in my and/or my families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my treatment at any time without consequence, but that I will remain responsible for payment for services that I have received. I have been informed of the risks and benefits of receiving these services and the risks and benefits of not receiving these services for myself, and/or for this minor and his/her family. _____ **(Please initial here)**

I understand there are procedures included in assessments that will test the validity of responses at multiple points throughout the course of the evaluation. If test performance suggests the examinee is not putting forth their best effort and/or if there is evidence of exaggeration of symptom report, test results may be invalid, leading to inconclusive findings. I agree to notify the clinician immediately if I feel unable to put forth my best effort during the evaluation. _____ **(Please initial here)**

I understand that any diagnoses from assessments will be based on the comprehensive review of available information and data and that results may not be consistent with the patient's/parent's hypothesis/assumptions. In addition, proceeding with an evaluation does not guarantee results will lead to a formal diagnosis. We try to schedule patients for focused testing to limit time and cost. However, at times a definitive diagnosis may require further assessment beyond the scope of the initially scheduled evaluation. _____ **(Please initial here)**

I understand that information provided during the clinical interview and in any correspondence will be included in the report if relevant to the case conceptualization. _____ **(Please initial here)**

I understand that the full report is what should be provided to any outside treatment providers and school (if applicable). Diagnosis letters without the full context of the report are not provided as it removes information pertinent to the case conceptualization and justification of any provided diagnoses and treatment recommendations. Only under very rare circumstances will a separate version of a report be provided for a specific recipient. _____ **(Please initial here)**

I understand and I have been informed that TWBHW center is fee for service and does not bill insurance. Many insurance companies may not pay for some therapies; and therefore, I agree to be responsible for all laboratory, pharmacy, therapies, and office visit charges, with the full understanding that I may not be reimbursed by my insurance company. TWBHW is not responsible for an insurance company's denial of payment. _____ **(Please initial here)**

I understand that I will be charged $125 if I/my child do not show up for an appointment or do not give at least 24-advance notice of a cancellation. I agree to be charged $125 for any missed appointments or cancelled appointments without 24-hour notice. Additionally, for when a deposit is required for a service, any no-show or late cancellations will result in the deposit being forfeited. _____ **(Please initial here)**

By signing, I certify I have read and understand the Consent for Treatment with The Woodlands Behavioral Health & Wellness Ctr.

_____ _____ _____

(Print Name of Client) (Client or Parent/Guardian Signature) (Date)

CONSENT FOR TREATMENT FOR MINORS

As a custodial parent/guardian of _____, I hereby give consent for him/her to receive
(Please Print Child's Name)
the following treatment from TWBHWC without me being present:

Therapy/Counseling/Coaching/Tutoring: _____
(Custodial Parent/Guardian Signature)

Psychopharmacology (medication) Follow-Ups: _____
(Custodial Parent/Guardian Signature)

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HIPAA: NOTICE OF PRIVACY PRACTICES (PATIENT COPY- please keep a copy for your records)

I. NOTICE OF PRIVACY PRACTICES

TWBHW is committed to confidentiality regarding client's records and presence in treatment. We will not disclose any information to anyone about you/your child unless you give us your WRITTEN consent.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. Written patient release information is usually required for the transfer of records. However, there are some exceptions where a minimal amount of information may be shared without a patient release and are specified below.

I understand that I have the right to inspect or copy Protected Health Information (P.H.I.) and/or psychotherapy notes unless it is determined this would adversely affect my well-being. To inspect and copy such information, you must submit your request in writing to the Privacy Officer, TWBHW. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies in connection with your request. We may deny you request to inspect and copy in certain instances. If we do deny access to medical information, you may request a review by another licensed health care professional chosen by us.

II. LIMITS OF CONFIDENTIALITY

I understand that the following disclosures **DO NOT** require authorization:

- When there is knowledge of, or reasonable cause to believe a child, elderly or disabled person is being neglected, physically abused or sexually abused or has been in the past. In which case, Texas statutes require that such information be reported to the proper authorities.
- Cases of threatened or suspected homicide. The appropriate police agency will be notified.
- Cases of threatened suicide. At least one concerned person and/or the appropriate emergency service agency may be contacted to intervene.
- Ordered by a court to disclose information.
- To health oversight agency (insurance).
- For workman's compensation.

III. COMPLAINTS

If you feel that your rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. If you want to file a complaint with us, contact the Privacy Officer of TWBHW. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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(TWBH Copy)

By signing, I certify that I have received and read a copy of the HIPPA: Notice of Privacy Practices and understand the information contained in the notice.

(Print Name of Patient)	(Signature of Patient/Guardian)	(Date)

By signing, I certify that I have received and read the Limits of Confidentiality and understand the information contained in the notice.

☐

(Print Name of Patient)	(Signature of Patient/Guardian)	(Date)

Please check the box if you agree to the following:

I consent to email communication/notification that may include medical information specific to my medical history, diagnosis, findings, treatments and/or recommendations.

Email Address: _____

Patient/Guardian Signature: _____

Print Name: _____

Date: _____

Witness: _____

THE WOODLANDS
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Services to Dependent Children of Divorced or Separated Parents
(Only necessary for parents who are divorced)

Please be advised you will need to provide TWBHW with a court recorded copy of your final divorce decree. This is to verify which parent has mental health/psychological rights for treatment for the minor child. A minor child will not be seen if we do not have a copy of the divorce decree. If the mental health/psychological rights have been modified in a modification order, you will need to bring both copies to the minor child's appointment, original divorce decree and original modification order. If your child is adopted you will need to provide us a copy of court recorded adoption papers with case number located on each page. This is to verify that the child is legally in your custody.

We understand that the above can be a burden. However, it is in everyone's best interest that we follow the law in regard to what parent(s) have mental health/psychological rights for treatment for the child.

If there is shared custody the following documents must be signed by both parents:

- Consent for treatment
- Payment Policies
- Authorization for Release of medical records

Fee for Service

The parent who brings the child for treatment will be responsible for payment at the time of service. If the parent does not wish to make payment, the child's appointment should not be scheduled and the center must be notified in order to forward a list of alternative providers to the parent to ensure continuous treatment for the child. We do not accept insurance.

Conflict Resolution

To protect the health of the child a pre-paid therapy session can be scheduled for both parents to try to resolve parental conflict about treatment as well as to discuss alternative venues for treatment.

AT NO TIME WILL EITHER AMINISTRATIVE OR CLINICAL STAFF INTERVENE WHEN A PAYMENT CONFLICT ARISES BETWEEN PARENTS. IN THIS SITUATION, PARENTS ARE ASKED TO WORK WITH THEIR ATTORNEYS TO RESOLVE PAYMENT DISPUTES.

I understand and agree with the above requirements:

Print Name: _____ Signature: _____ Date: _____
(Print Name of Parent) (Signature of Parent (Date)

Print Name: _____ Signature: _____ Date: _____
(Print Name of Parent) (Signature of Parent (Date)

2700 Research Forest Dr. #130 ● The Woodlands, Texas 77381
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THE WOODLANDS
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HIPAA Consent Form for AI-Assisted Note Writing The Woodlands Behavioral Health & Wellness Center

Purpose of This Consent
This form provides information and seeks your consent for the use of artificial intelligence (AI) tools to assist in clinical documentation, including therapy notes, assessments, and progress tracking. These tools are used to improve accuracy, reduce administrative burden, and enhance your care experience.

What You Need to Know

- AI Use in Documentation: We use HIPAA-compliant AI software to transcribe and summarize session notes. These tools do not make clinical decisions or diagnoses.
- Data Security: All data processed by AI tools is encrypted during transmission and storage. Access is restricted to authorized personnel only.
- Business Associate Agreements (BAAs): Our AI vendors have signed BAAs, ensuring they are legally bound to protect your health information under HIPAA regulations.
- No Sharing for AI Training: Your data is not used to train or improve AI models. It is only used for your care.
- State Compliance: We also comply with the Texas Medical Records Privacy Act, which may impose stricter protections than federal HIPAA rules.

Your Rights

- You may decline the use of AI-assisted documentation without affecting your access to care.
- You may request access to your records and ask for corrections.
- You may withdraw consent at any time by notifying our office in writing.

Consent Statement
I acknowledge that I have read and understood the information above. I understand that The Woodlands Behavioral Health & Wellness Center clinicans (*Dr. Brett Kramer, Dr. Jim Zettel as of 9.5.25)* use AI tools to assist in clinical documentation and that these tools comply with HIPAA and Texas privacy laws. I consent to the use of AI-assisted note writing during my care.

Patient/Guardian Signature: _____

Print Name: _____

Date: _____

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PAYMENT TERMS

Fees

_____ **Initials**

By initialing, you acknowledge that you have been given a current fee sheet.

No Insurance Billing

_____ **Initials**

By initialing, you understand that The Woodlands Behavioral Health & Wellness Center **does not** accept or process insurance. While we don't contract with insurances, you will be given an insurance-ready receipt which you may provide to your insurance company to try to obtain reimbursement. For your convenience, we accept cash, checks or credit cards as payment.

Although we are not able to be directly involved if you seek reimbursement from third party payers, we can assist by providing a statement of services, dates, charges, procedure and diagnostic codes. We are unable to complete in-depth (2+pages) HCVA forms, fill out other authorization or referral forms, make phone calls, or take part in an appeals process for payment.

Cancellation Policy – Part A

_____ **Initials**

By initialing, you understand that we require a minimum of 24-hour cancellation notice prior to any appointment. You will be charged **$125.00** for failure to provide the minimum 24 hours' notice of cancellation or if you No Call/No Show (NCNS). For late cancellations or NCNS for assessments, which require a deposit, the deposit will be forfeited. If you choose to make another appointment, another deposit will be required.

No Call/No Show (NCNS) Policy

_____ **Initials**

After the 1st No Call/No Show (NCNS)or Late Cancellation with a Psychiatrist, you will be required to pre-pay for all appointments. If you NCNS or you cancel within 24 hours, the cost of the appointment will be forfeited.

For any other clinician, after two (2) NCNS or Late Cancellations, you will be required to pre-pay for all future appointments. If you do not come or you cancel within 24 hours, the cost of the appointment will be forfeited.

By initialing, you have read and understand our No Call/No Show Policy.

Prescription Refill (RX) Policy

_____ **Initials**

To ensure timely medication refills, we require our clients to give us **two weeks' notice**. Each time our psychiatrists refill one of your prescriptions, **they are required to review your chart**. You will be charged a **$15** fee for all refills requested outside of regular follow-up appointments. Additionally, all Schedule II Drugs (stimulants) expire after 21 days. If you require a new RX because of expiration, you will be charged an additional fee. Prescription Refills (outside of appointment) needed within 2 business days of request will be charged a $25 rush fee. By initialing, you acknowledge you have read and understand the Prescription Refill Policy.

School Accommodations

_____ **Initials**

Part of our services include assisting with school accommodations, but it is necessary for us to bill for the clinician's time spent at meetings (in person or via the phone) with teachers or counselors as well as time spent writing letters or specific recommendations. An estimate of time needed can be given on an individual basis. By initialing, you understand the billing associated with our clinicians travelling to schools and/or communicating with school staff for meetings, information, etc.

Legal Report Writing, Depositions and Testimony

_____ **Initials**

If legal services are requested, additional forms and a retainer will be required depending on services. All services provided, and expenses incurred by the clinician for court-related issues such as but not limited to review of documentation, contact with attorneys, dispositions, travel and courtroom proceedings will be charged to the client at **$750 per hour.** By initialing, you understand legal services require additional forms and are charged $750 per hour.

Returned Check Fee

_____ **Initials**

By initialing you understand there is a $35 fee for all returned checks and agree that you will be required to pay the balance with a credit card.

Credit Card Processing Fee

_____ **Initials**

By initialing you understand there is a 3.5% processing fee for all credit card transactions.

By signing below, I acknowledge that I have read and understand each of the set forth payment terms.

_____	_____	_____
(Printed name of Client)	(Signature of Client/Guardian (if minor))	{Date}

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CREDIT CARD AUTHORIZATION

You may choose to keep your credit card on file for payment purposes. If you choose to do so, please complete the following information:

Today's Date_____**Patient Name**_____

Name on Credit/Debit Card_____

Billing Address:_____**City & State:**_____**Zip Code:**_____

Credit Card Type: Visa MasterCard American Express Discover **Expiration Date**_____
(*Please circle one)* *(mm/yy*

Acct. Number_____

CVV/Security Code (3 digits on back of card/ 4 digits on front AmEx)_____)

I give permission to maintain this credit card on file, and for TWBHW to process all future charges using this credit card unless otherwise noted. I understand there is a 3% convenience fee for all credit card transactions. The card will be charged for any outstanding balances when necessary. I will notify TWBHW with updated information as it is available.

_____ _____ _____
Printed name of Client *Signature of Client/Guardian (if minor)* *Date*

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THE WOODLANDS BEHAVIORAL HEALTH & WELLNESS CENTER

Authorization for Release of Information

PLEASE COMPLETE SEPARATE RELEASES FOR ADDITIONAL PARTIES
(I.E. SCHOOLS, PHYSICIAN'S OFFICES, FAMILY MEMBERS. ETC.)

Client Name_____ **DOB**_____

I hereby authorize the following person/facility to **receive / release** (circle one or both) information relating to me/my child's medical, educational, and mental health history with The Woodlands Behavioral Health & Wellness Center:

Name of Person:_____

Company/School:_____

Relation:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

For the following purpose *(Please check one)*: ☐ Mental/Medical Care ☐ Legal ☐ Other (specify below)

Please specify what information you authorize our clinic and/or requesting parties to be released:

◯ Specific Dates:_____ to _____ ◯ All Dates

☐ Entire Record	☐ Mental Status Exam	☐ School Meeting Information
☐ Admissions Notes	☐ Progress Notes	☐ School/Work Accommodations
☐ Medication Records	☐ MD Orders	☐ Rating Scales
☐ Discharge Summary	☐ School Reports/Testing	☐ Treatment Plans
☐ Psychological/Diagnostic Testing	☐ Verbal ONLY	☐ Financial Information
☐ Scheduling	☐ Emergency Contact	☐ Other:_____

You have the right to revoke this authorization in writing at any time by sending written notification. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorizing may be subject to re-disclosure by the recipient of your information and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

_____ _____ _____

Printed name of Client/Guardian | Signature of Client/Guardian | Date

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