Dr. Margaret Baier

PhD., LMFT
Baier Equine Assisted Retreat, LLC
Licensed Marriage and Family Therapist
2121 W. Waco Drive, Waco, TX 76707

Patient Information and Consent Forms

Name of Client #1____ Date _______________

Address____City___________________ Zip _____________

Cell Phone ____________________ Other Phone ______________________ Email_____________________

Birth date ___________ Age ____________Marital Status ____________

Name of Client # 2____ Date _______________

Address____City___________________ Zip _____________

Cell Phone ____________________ Other Phone ______________________ Email_____________________

Birth date ___________ Age ____________Marital Status ____________

Optional:

Medications ____

Major Health Problems ____

Describe your reason for seeking treatment at this time:* ____

____

In case of emergency notify ____________________ Relationship ____________ Phone ________________

Therapist Disclosures & Informed Consent

Duty to warn: State law requires that a therapist must inform child protective services if child abuse is suspected or revealed. Therefore, any information regarding this issue will be reported to the Child Protective Service Agency. I will also inform an individual and/or the proper authorities when a life-threatening accusation is made toward one's self or about another individual.
Confidentiality: Therapists are bound by their code of ethics to keep all information shared in the therapy session confidential. This rule can be broken only if the duty to warn is enforced by the therapist. Minor children's right to confidentiality will be discussed both with the parents of the child(ren) and the child(ren). Decisions regarding child confidentiality will be made on a patient-by-patient basis. Please discuss this matter thoroughly with the therapist.

Records: This practice is HIPPA compliant and patient records are protected. The therapist will retain patient records for 7 years following termination of treatment. After 7 years, the records will be destroyed unless there have been further transactions, therapy, or claims between the patient and therapist. As movement is made toward becoming "paperless", all electronic records will be protected and will not be transmitted electronically unless encryption is available. Be advised: The records that belong to the patient include the intake form and accompanying documents and billing records which may include diagnoses and treatment procedures. The records that belong to the therapist and may not be shared with the patient include any notes made by the therapist for the purpose of facilitating treatment. Release of records must be accompanied by a signed Release of Information that specifies to whom information should be released, for what purpose this information will be released, and the duration of the authorization.

Conduct of Therapy: The therapist shall adhere to the code of ethics of the American Association of Marriage and Family Therapy in addition to other professional counseling organizations (whichever is most stringent) and to the laws of Texas as they pertain to patient-therapist relationships.
Complaints should be address to: The Texas State Board of Examiners of Marriage & Family Therapists, 1100 W. 49th Street, Austin, Texas 78756

I have read and understand the therapist disclosures and the limitations of confidentiality.

Patient #1 signature ____ Date ______________

Patient #2 signature ____ Date ______________

Patient #3 signature ____ Date ______________

Patient #4 signature ____ Date ______________

Patient #5 signature ____ Date ______________

Therapist signature ____ Date ______________

Patient-Therapist Agreement

Fees are an important issue to anyone receiving professional services.
This sheet was prepared to clarify fee policies.

Fee Rate: The basic fee for therapy is $150.00 for 50 minutes. Longer or shorter sessions are prorated from this basic fee.

Psychological testing is not part of this practice. Patients will be referred to the appropriate person(s) for any necessary testing. If you desire official documents regarding treatment, these will be provided at the rate of $200.00 each in order to cover the time required to prepare these documents and will not be released until you have made full payment for this service.

Fees for court appearance, requested by you, your attorney, or through a subpoena, are $200.00 per hour. You will be responsible for all my time, including time for driving to court, waiting to testify, giving testimony, as well as preparation and/or research time that is required. Because it is necessary for me to block off my schedule for at least half a day in order to appear in court, you will be charged for a minimum of four hours of my time for each day in court. Payment for this four hour minimum is required one day prior to court hearing.

Phone Consultation: The standard prorated fee will be charged for telephone time.

Payment Method: Payment is required at the time services are rendered. Payment may be made by check or cash or credit card.

Missed Appointments: If you are unable to keep an appointment, please notify me immediately. If an appointment is cancelled or missed without 24 hours' prior notice, you may be billed for the session. Additional appointments may not be made until payment for the missed session is tendered.

By signing this agreement, the patient agrees s/he has read it carefully and has received a copy of both the fee agreement and the page titled "Therapist Disclosures & Informed Consent." The patient agrees to bring any and all questions or concerns that may arise regarding these fee policies.

Patient's signature (or responsible party) ___________________________________ Date ____________

Request & Consent for the Release of Confidential Information

I authorize ___________________________________to release information regarding my medical/psychological history to:

Margaret Baier, Ph.D. LMFT
Licensed Marriage & Family Therapist
Records & Billing Office
1000 Sommerfeld Drive
Waco, Texas 76705

I hereby give my consent for any and all of the requested information to be released
_____ one time only ______ongoing as need to facilitate treatment

Signature of Client or Authorized person ___________________________________

Authorization to Release Information

I authorize Dr. Margaret Baier to release information regarding my treatment in therapy to the following person(s), medical facility, or school:

Name ___________________________________Organization_____________________________
Address ___________________________________ Phone__________________________________

I hereby give my consent for any and all of the requested information to be released
___ one time only ___ ongoing as need to facilitate treatment
Signature of Client or Authorized person __________________________________ Date ____________