Behavioral Solutions of Texas
8530 FM 1960 Rd E. Suite 107
Humble, Texas 77346
Tel# (281)-713-9004
Fax# (281)-973-2494
Website: www.behavioralsolutionsoftexas.com

Here at our office, we take our scheduling seriously so that each patient receives the right amount of time to be seen by our therapist. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy and to help patients remember their scheduled appointments, Behavioral Solutions of Texas sends text messages, email and calls - 3 days and a day before the scheduled appointment.

And for any reason your schedule changes and you cannot keep your appointment, please contact the office phone number (281)-713-9004 so we can reschedule you, and to accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients that are waiting to be scheduled with our therapist, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $35.00 "NO SHOW"or late cancellation service charge to your account. This "NO SHOW" late cancellation charge is not reimbursable by your insurance company. You will be billed directly for it and MUST be paid before rescheduling.

After three (3) consecutive no- shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "NO SHOW" policy of Behavioral Solutions of Texas and agree to pay the $35.00 charge for any no-show and last-minute cancellation fee of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show fee.

_____

Guardian or Patients Signature

_____

Date

Behavioral Solutions of Texas, LLC
8530 FM 1960 Rd E. Suite 117
Humble, Texas 77346
Tel # (281)-713-9004
Fax # (281)-973-2494
Joseph Brown, LCSW-S, LSOTP-S, LCDC
Website:www.behavioralsolutionsoftexas.com

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider offers telehealth sessions and I am opting to engage in telehealth rather than face-to-face sessions.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

6. I understand that my insurance company may not cover telehealth sessions and agree to self pay if not covered by my insurance

CONSENT TO USE THE TELEHEALTH BY Doxy.me SERVICE

Telehealth by Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Doxy.me Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me

• That I fully understand its contents including the risks and benefits of the procedure(s).

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I understand that I am required to be in one location for telehealth services. Please list the address below

I understand that I will be required to confirm my physical location at each telehealth session. If I am not able to be at the location above I may be asked to reschedule the session.

*** BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

By checking this, you are eSigning this form.

Joseph Brown, LCSW-S, LSOTP-S, LCDC

www.behavioralsolutionsoftexas.com

Patient Name_____

Patient Signature _____ Date_____

Therapist Signature _____ Date_____

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Attendance in Court Cost Per Therapist

1. Preparation time (including submission of records): $175/hour
2. Phone calls: $175/hour
3. Depositions: $220/hour
4. Time required in giving testimony: $225/hour
5. Mileage: $0.58/mile
6. Time away from office due to depositions or testimony: $220/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance: $3500

A retainer of $3500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48 hours advance notice, there will be an additional $250 "express" charge. If the case is reset with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer of $3500).

Clients are discouraged from having their therapist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that our testimony will be solely in your favor. We can only testify to the facts of your case according to our professional opinion

Behavioral Solutions of Texas, LLC

** I (Client name) _____ have read, understand and agree to the above charges.

(Client Signature) _____ Date _____

SASSI Questionnaire Behavioral Solutions of Texas, LLC

First Name:

Date of Birth

Last name

Address:

Email:

Phone/Cell:

Program:

☐ Intensive Outpatient Program

☐ Supportive Outpatient program

☐ Mental Health Evaluation

Race/Ethnicity Other

Employment Homemaker

Age

Marital Satus Unmarried Couple

Number in Household 1

Highest Grade Completed GED

Client History

Number of Total Arrests

Number of DUI/DWI Arrests

Prior Alcohol/Drug Treatments None

By Signing I understand that No Show (less than 24 hour notice) Intake appointments will result in a $35 reschedule fee. It is my responsibility to be in a clear WIFI connection and that I may not be diving or riding in a vehicle. Initials:

Signature:_____ Date:_____

Behavioral Solutions of Texas,LLC

Adult and Family Psychotherapy

DATE

8530 FM 1960 RD E. Humble, TX. 77346 PH. (281)713-9004

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, hereby authorize Joseph Brown LCSW, and Behavioral Solutions of Texas,LLC and _____(probation officer) PO Email _____ PO Phone_____ to exchange information.

The type of information to be disclosed: Evaluations, Diagnosis, Treatment Plan, Course of Treatment
The purpose of such disclosure: Ongoing Treatment, Evaluation, Coordination of Care which may include: Medical/Hospital Records, Psychological/Medical Test, Results of Mental Health Record, Summary Psychotherapy Notes.

Initials

All information about me may be transmitted by fax, electronic message and other electronic file transfer mechanisms.

Behavioral Solutions of Texas, LLC and Joseph Brown LCSW-S and the above designated Probation or Court Officer may discuss and share the all information.

This consent is in effect until I revoke this authorization, in writing, at any time unless action based on it has already take place.
I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.
I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.
I further understand that the potential exists for re-disclosure of my self/son/daughters private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.
This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Signature

Mental Health Evaluation Intake Information

Please fill out all information completely

Behavioral Solutions of Texas, LLC Children & Families Location
8530 FM 1960 Rd. E. Suite #107 Humble, Texas 77346

Adult Sex Offender Assessment & Treatment Location1931 Humble Place Dr., Suite 107, Humble, TX 77338
Joseph Brown LCSW-S, LSOTP-S, LCDC-S

What was your index (current) arrest for?

How long your sentence?_____ Deferred ☐ Yes ☐ No

Why were you asked to complete this evaluation?

Have you been arrested before? ☐ Yes ☐ No

How Many Times?_____

What were the previous Charges?

Are you currently Married? ☐ Yes ☐ No

How long?_____

How Many Biological Children in this marriage? Stepchildren?

How many Previous Marriages?_____

If no marriages have you been in a relationship for 2 years? Yes ☐ No ☐

Many Times?_____

How Many Biological Children? _____ Were you in all of their lives?_____

Did you pay child support?_____ Are you behind on support? Yes ☐ No ☐

Mother living? Yes ☐ No ☐ Father Living? Yes ☐ No ☐

many Siblings?_____

How Do You get along with your family?

Behavioral Solutions of Texas, LLC
8530 FM 1960 Rd E Ste 107
Humble, TX 77346-1831
Telephone: (281)713-9004

Behavioral Solutions of Texas, LLC.
CSC ZOOM SESSION RULES AND ATTENDANCE POLICY

Name: _____ **Date:** _____

These guidelines are necessary to maintain the integrity of our On Line therapeutic sessions. Groups must function as though clients and therapists are in an office setting.

1. **Client is responsible to be in clear and stable WIFI connection**
   a. If no clear connection is available in office sessions are required.

2. **Client must be stationary - no driving or riding in a vehicle and no walking/moving.**

3. **Client must be in a private location with no one else in the room/car**

4. **Client must be fully and appropriately clothed during the session**

5. **Client Must have face consistently visible in the camera - no cameras can be obstructed**
   a. Backgrounds may not obstruct a clear view of the clients face.

6. **Clients may not be admitted to group after 5 minutes late, after 5 minutes late session will be counted as No Show. Regular session fee will apply.**

7. **No Show or late Cancel sessions without Medical Excuse must be made up. Regular session fee will apply.**

8. **Failed Drug screens must be reported and an individual session scheduled-No exceptions. Relapse/drug or alcohol use should be reported during group**

9. **No Smoking or Vaping during Group**

10. **Clients will be responsible to reschedule sessions with the office. Therapists may approve make up sessions during group only-- Email, text or phone calls with the therapist will not count as notification.**

11. **Noncompliance with any of the above rules will be counted as No Show and the session will not be considered complete. Clients will be responsible for payment of LATE CANCELLATION AND NO SHOW.**

I have read and understand that I may be not receive credit for Zoom sessions if I am not able to comply with these policies.

_____ _____

Signature Date

RELEASE and WAIVER

RELATING TO PROVIDING COUNSELING RECORDS AND COMMUNICATING PERSONAL HEALTH INFORMATION TO:

Harris County Community Supervision and Corrections Department

I, _____, in all capacities and in consideration of counseling and assessment services provided by **JOSEPH BROWN LCSW-S,** and any and all counselors and staff of Behavioral Solutions of Texas, LLC (all collectively referred to as "Behavioral Solutions of Texas, LLC"), do hereby release them and hold them harmless from disclosing copies of and the content of my records, including my therapy and counseling records and assessments, as well as releasing them and holding them harmless for providing any oral or written communications relating to any information concerning my mental or emotional health, or substance abuse history or status.

Included in this release is my voluntary approval for the release by Behavioral Solutions of Texas, LLC of my personal health information described above, including to individuals or entities associated with state or federal agencies, such as the Department of State Health Services or Health and Human Services Commission or the Harris County Community Supervision and Corrections Department. I understand that such information eligible to be disclosed encompasses all of my personal health information, including my substance abuse history, substance abuse issues, substance abuse-related information from the current case, and results of drug tests.

I understand that a part of my care at Behavioral Solutions of Texas, LLC involves screening and assessment of my substance abuse status and what type of substance abuse services I may need. I specifically authorize Behavioral Solutions of Texas, LLC to disclose all of my personal health information as is needed to convey my history and current status, such disclosure being potentially made to Harris County Community Supervision and Corrections Department, and those associated with them including attorneys, Department of State Health Services or Health and Human Services Commission, and to law enforcement, attorneys, and courts with jurisdiction over any matter where my personal health information would be relevant to their proceedings. I understand that there may be other individuals and entities to which the disclosure of my records and personal health information needs to occur, and I authorize Behavioral Solutions of Texas, LLC to make such disclosures as they deem necessary.

These individuals and entities are released of, from and against any and all demands, actions, liabilities, obligations, judgments, executions, causes of action or other claims (collectively called "claims") in connection with any injuries or damages to myself allegedly caused by the alleged acts, omissions or other fault of the individuals and entity hereby released. This Agreement includes, but is not limited to, all matters relating to care and treatment provided at any time to me by Behavioral Solutions of Texas, LLC, **JOSEPH BROWN LCSW-S** and or his offices.

I am legally and mentally competent to execute this release agreement and have voluntarily done so.

Signature: _____

Date: _____