INDIVIDUAL SERVICE AGREEMENT AND OFFICE POLICIES

I understand that my engagement with Calm and Clear Mind Center (herein referred to as "The Center") or any of its providers, affiliates, or staff members are based on the following agreement. Therefore, I acknowledge and agree that any breach of these agreements may result in the termination of any and all of my relationships with The Center or any of its providers, affiliates, and/or staff members.

I understand that I (the "Client") am fully responsible for the payment of all fees for services provided regardless of insurance coverage I may have. By initialing each section below, I attest that I have read, fully understand, and agree to each of the policies contained herein. I understand and agree that it is The Center's policy that the fee for any service provided is payable at the time of service. I understand that Calm and Clear Mind Center accepts cash, checks or credit cards as forms of payment.

I further understand, acknowledge, and agree that if my child(ren) is (are) receiving services at The Center that I am agreeing to all the terms below and agree that I am the party responsible for any and all charges that are incurred on behalf of my child or any minor legally in my possession.

***Please INITIAL all below:**

Phone Consultations: _____

I understand and agree that while sessions are not conducted by phone, should I feel the need to speak with my provider in between regularly scheduled visits at The Center, I may request the office staff of The Center to arrange a phone consultation between myself and my provider. I understand that any such consultations will be considered emergency services by The Center, and that any fees associated with these services are not billable to my insurance carrier (company). If an emergency phone consultation is initiated by me (the "Client"), The Center reserves the right to apply a $25.00 fee to my account for each period of up to 15 minutes. I also understand that, as The Center is not equipped to provide emergency services, my provider may not be available for immediate consultation, and that I will be connected with my provider at his or her earliest convenience. I understand that in a true crisis situation, I will be advised by The Center to contact appropriate local emergency personnel, or to seek treatment in an emergency facility.

Insurance:_____

I understand and agree that I am ultimately responsible for any and all fee(s) not covered by my insurance carrier. I understand that my insurance policy is a contract between my insurance company and me, and therefore will not hold Calm and Clear Mind Center responsible for their denial of coverage or for negotiating claims with insurance companies or other individuals. I agree that non-covered services are payable at time of service unless other arrangements have been made. In the event that my insurance carrier declines my benefits, I acknowledge and agree that I am fully responsible for the declined charges and can expect them to be applied to my account and/or charged to the credit card I have placed on file with The Center. I further acknowledge that Calm and Clear Mind Center and its providers do not guarantee that payments will be authorized by my insurance company for services rendered; therefore, I acknowledge that I will not hold Calm and Clear Mind Center responsible for any adverse payment decisions or financial hardships that result from their denial of payments.

Extended Sessions: _____

I understand and agree that the standard length for a counseling session at The Center is 45-55 minutes, and that any session in excess of this shall hereby be considered an "extended session." I hereby agree that I will be responsible for paying any such out-of-pocket fees associated with "Extended Sessions", and that failure to do so may result in the closing of my file and the termination of my relationship with The Center.

Responsibility of Providers: _____

I understand and agree that it is the purpose of providers at The Center to provide me (the "Client") with quality treatment during my sessions. As such, I understand that it is not my provider's responsibility to inform me of any incidental charges that may accrue during or as a result of my session (such as charges for "Extended Sessions").

Forms, Letters, and Report Requests: _____

I understand and agree that due to the amount of time it takes The Center and its providers to prepare and process forms (i.e. short-term disability, FMLA, etc.), letters (i.e. to school, employers, etc.), and reports (i.e. for court purposes) requested by me and/or related to my treatment, The Center will charge a $60 - $120 fee for completing and processing these requests. I understand and agree that this fee is payable at the time the request is made and can be charged to my credit card on file. Please Note: The Center will not be able to complete any forms for filing long-term disability. Such forms need to be completed by an alternative healthcare provider, typically your primary care physician.

Medication Refill Requests: _____

I understand and agree that it is my responsibility to schedule my medication management appointments as recommended by my psychiatrist in order to avoid lapses in medication.

Legal Proceedings: _____

By signing this Service Agreement, I (the "Client") acknowledge that I am entering into a therapeutic relationship with a provider at Calm and Clear Mind Center. I understand that, because of the nature of this therapeutic relationship, it is not the general practice of The Center or its providers to provide legal or forensic services. As such, I agree that in the event that any provider or staff member of The Center is subpoenaed, summoned, noticed, or in any way requested or commanded to give testimony, produce records, appear, or in any way be involved in any type of legal proceeding, that the therapeutic relationship will be considered immediately terminated. At that time, The Center will no longer provide counseling or related therapeutic services, but will fulfill court mandated legal obligations on a factual or forensic basis.

I agree that The Center will charge $325 per hour for actual time in court (including giving depositions), time spent waiting to testify, time spent preparing to testify including reviewing records, time spent traveling to and from the location of legal proceedings, and any time spent by staff of The Center at a rate of $75 per hour for coordinating schedules, compiling and assembling records, filing any notices, motions, etc. I further agree that I must retain The Center for at least an 8-hour period for $2,600 (customary work-day) by arranging for the payment to be paid to The Center before any subpoena is honored. I agree that the $2600 retainer must be paid with either a Cashier's Check or Money Order. I understand that The Center will refund any remaining balance of the retainer no later than 60 days after all court proceedings have concluded.

I agree that if I, or any person that was present during any counseling or therapy session, subpoenas, summons, notices, or in any way requests or commands any provider or staff member of The Center to give testimony, produce records, appear, or in any way be involved in any type of legal proceeding, that such subpoena, summons, notice, or other request will been deemed invalid and void until, unless: (1) the retainer fees for The Center's Provider have been secured and (2) a HIPAA authorization to release information form has been filled out and signed by ALL parties that have been present during any counseling or therapy sessions. I agree that unless both of these conditions have been satisfied, The Center will engage an attorney to file appropriate legal responses, including, but not limited to, an Objection and Motion to Quash citing that this contractual agreement with the Center has not been satisfied.

I agree, that if The Center or any of its providers or staff members incurs any financial expense for legal representation as a result of any legal proceeding as that I, or any person that was present during any counseling or therapy session, is involved with, that I will be fully responsible for the re-payment of such expenses. I further agree that in the event that The Center incurs any financial expenses for legal representation as a result of my actions, I authorize The Center to immediately charge all such expenses to my credit card on file (see Credit Card Authorization Form). Alternatively, those expenses can be deducted from the retainer I have placed with The Center.

Hospital or Psychiatric Site Visitations: _____

I understand and agree that, it is not the general practice of The Center or its providers to make any hospital or off-site visits. However, in the event that I or a family member of mine make a request, a visit is deemed absolutely necessary and, a provider is willing, at his or her own discretion, to make a visit for my benefit, The Center will charge $140 per hour for actual time out of the office (including traveling to and from the hospital).

Psychological Assessments: _____

I understand and agree that, if I request to complete a psychological assessment provided by Calm and Clear Mind Center, or if my provider recommends that I complete such assessments that I am solely responsible for any and all costs associated with the administration and reporting of the results. I understand that it is the policy of The Center that psychological assessments are not billed to any third party payers, including my insurance company. I understand that I may request a receipt to be provided to me, so that I can seek reimbursement for the charges.

Missed Appointment and Late Cancellation Policy: _____

I understand and agree that if I am unable to attend my appointment, ***I must cancel or reschedule before 12:00 p.m. on the business day prior to the scheduled appointment at The Center.*** Cancellations received after this time will incur a $75 fee applied to my account and charged to ***my credit card on file (see Credit Card Authorization Form).***

I understand that excessive tardiness for an appointment will be considered a missed appointment and will incur a $75 fee. For therapy appointments, excessive tardiness is considered to be anything more than 30 minutes past the scheduled appointment time. As the duration of psychiatry appointments vary, excessive tardiness will be determined on a case by case basis. The Center will make every effort to fit in your appointment, but if this will result in a delay for other Clients who are on time, The Center will consider your appointment as missed and request that you reschedule for another time.

I understand that a late cancellation or a 'no-show' cannot be claimed on my insurance plan and that I will be responsible for the $75 fee for late cancellation and a nonrefundable full payment fee for no-shows. I understand and agree that The Center will charge my credit card on file for no- shows or late cancellations. If payment is not secured through credit card, I understand that I will not be able to schedule another appointment with The Center until I have paid the balance on my account. I further acknowledge and agree that my failure to pay these fees may result in the closing of my file and the termination of my relationship with The Center.

I understand that The Center's voicemail system records the day and time of all messages left, so that even if no one is available to take my call, or to cancel a Monday appointment, I can call and leave a voicemail requesting to cancel my appointment and that the office staff of The Center will be provided with an accurate record of the time and nature of any cancellation. I understand and agree that accumulation of **3 or more** no-shows or late cancellations may result in the closing of my file and the termination of my relationship with The Center.

I understand that there will be a courtesy automatic email reminder of the appointment sent out. However, I understand that these reminders are a ***courtesy*** to me (the "Client"), and that, on occasion, circumstances may prohibit the completion of this task by office staff. I understand that managing my scheduled appointments is ultimately my responsibility, and that the "Missed Appointment and Late Cancellation Policy" and related fees are applicable regardless of my receipt or lack thereof of a reminder from the Calm and Clear Mind Center.

I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing the community and me a valuable service. My appointment time is reserved for me at the exclusion of others who may be waiting to see a provider. Since The Center is a fee-for-service clinic, my late cancellation or failure to show for an appointment may result in a loss of income for the providers and/or The Center in addition to keeping others from getting the help they may require.

Miscellaneous Service Charges: _____

I understand and agree Calm and Clear Mind Center charges $30 for the first 20 pages of medical records for their processing, preparation, and printing. I understand each page after the first 20 pages will incur a $0.50 charge per page. I understand that it may take up to 15 business days to obtain my records.
I understand that returned checks are subject to a $35 service fee. Any returned checks and associated fees must be resolved before any future appointments can be arranged or scheduled.
I understand and agree that if The Center has to pay ANY fees to a third party (i.e. collection agency, attorney, court costs, etc.…) for collection of payments, that based on this agreement, I will be responsible for those payments in addition to any service fees owed to the Center.

Revision of Agreements and Policies: _____

I understand and agree that Calm and Clear Mind Center reserves the right to review, revise, and otherwise modify this "Service Agreement" as necessity demands, without obtaining my express consent, and further acknowledge and agree that such changes in no way nullify my signature on this agreement, or release me from any of the financial or contractual obligations contained herein.

Termination of Services: _____

I understand and agree that as of the date of my first appointment at The Center, I am entering into a therapeutic relationship with my provider. I understand that the success of therapeutic treatment is dependent upon a commitment to consistent attendance of regularly scheduled sessions, until such a time, mutually agreed upon between me and my provider, as such sessions are deemed no longer necessary. I further acknowledge that my absence in the therapeutic relationship, defined by a consistent lack of scheduled appointments or other communication with my provider and/or the support staff of The Center for a period of six months, will result in the closing of my file, and the termination of this relationship. I understand that I am free to contact The Center at any point after said termination, reinstate the therapeutic relationship, and resume my treatment at The Center.

Electronic Signatures: _____

I understand and agree that if this agreement, agreements ancillary to this agreement, and related documents entered into in connection with this agreement are signed when a party's signature is delivered by facsimile email, or any other electronic medium. These signatures are and must be treated in all respects as having the same force and effect as original signatures.

Severability: _____

I understand and agree that if any one or more of the provisions contained in this agreement is, for any reason, held to be invalid, illegal, or unenforceable in any respect, that invalidity, illegality, or unenforceability will not affect any other provisions of this agreement, but this agreement will be construed as if those invalid, illegal, or unenforceable provisions had never been contained in it, unless the deletion of those provisions would result in such a material change so as to cause completion of the transactions contemplated by this agreement to be unreasonable.

My signature below affirms that I have read and understand the service agreement and office policies of Calm and Clear Mind Center. I acknowledge that all of my questions have been fully answered, and that I understand that if more questions arise, I have the right to have them answered as well. I further acknowledge, understand, and agree that such terms may be amended from time to time to meet the needs of the practice.

Name of Responsible Party (please print):

Signature:_____ Date:_____/_____/_____

ACKNOWLEDGMENT OF RECEIPT OR ACCESS TO
"NOTICE OF PRIVACY PRACTICES"
You may refuse to sign this acknowledgment.

By signing this form, I acknowledge that I have been provided a copy of the "Notice of Privacy Practices" of Calm and Clear Mind Center, or have been informed that a permanent copy of the "Notice of Privacy Practices" is placed in the waiting area of Calm and Clear Mind Center, and that I may access or read it at any time I so choose.

I understand that the "Notice of Privacy Practices" provides information about how Calm and Clear Mind may use and disclose my protected health information, and that said notice is subject to change. I understand that, should any changes be made, I may obtain a copy of the revised notice by requesting a copy at any office visit, or by downloading the revised version from the Calm and Clear Mind website.

I understand that questions about the "Notice of Privacy Practices" should be directed to:

HIPAA Compliance Officer
Calm and Clear Mind Center
1208 Village Creek Dr. #104
Plano TX 75093
(945) 400-9093

I acknowledge receipt of the "Notice of Privacy Practices" of Calm and Clear Mind Center.

_____ _____
Name of Client (Please Print) Date

_____ _____
Signature of Client Date

_____
Signature of Client Representative (Required if the client is a minor or an adult who is unable to sign this form)

_____
Relationship of Client Representative to Client

INABILITY TO OBTAIN ACKNOWLEDGMENT – FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of the "Notice of Privacy Practices," but acknowledgment could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited the acknowledgment
☐ An Emergency situation prevented us from obtaining the acknowledgment
☐ Other (Please Specify):

_____

Office Representative's Name: _____ Position: _____

Office Representative's Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION FORM
REQUIRED FOR ALL PATIENTS / CLIENTS

Missed Appointment and Same-Day Cancellation Policy:

Calm and Clear Mind Center ("The Center") is responsible for reimbursing its providers for the patients/ clients seen at the center. As such, it is the policy of The Center that all cancellations or changes in your appointment time be confirmed by shows or late cancellations. If payment is not secured through credit card, I understand that I will not be able to schedule another appointment with The Center until I have paid the balance on my account. I further acknowledge and agree that my failure to pay these fees may result in the closing of my file and the termination of my relationship with The Center.:00 p.m. the day prior to the scheduled appointment. As a **courtesy,** our office will attempt to send a reminder email with the appointment details of your upcoming appointment 24-48 hours in advance of your scheduled session.
If you decide to cancel a scheduled session after the above-specified time, or are excessively late for your appointment, a $75 late cancellation or 'no-show' fee will automatically be charged to your designated card below. For Monday appointments you may call and leave a voice mail on The Center's confidential voice mail service indicating your wish to cancel your appointment. This is required so that The Center can reimburse the provider that has otherwise been unable to see another patient/ client due to the scheduling of your appointment.

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MASTERCARD ☐ DISCOVER

CREDIT CARD NUMBER:_____ - _____ - _____ - _____

EXPIRATION DATE:____/____ CSV:_____ CARDHOLDER'S NAME:_____

BILLING ADDRESS (IF DIFFERENT FROM INITIAL INTAKE)

_____

I fully understand and agree to the terms and policies of Calm and Clear Mind Center as set forth and acknowledged in the "Service Agreement and Office Policies" document and authorize The Center to charge any outstanding balance on my account to the above provided credit card.

_____ _____
SIGNATURE DATE