



SUPERVISED THERAPUTIC VISITATION PROGRAM

Intake Packet

Tania Glenn, PsyD, LCSW, CTS

Tania Glenn & Associates, PA

4412 Spicewood Springs Road Ste. 701

Austin, Texas 78759

512-323-6994

512-323-9490 (fax)

Dear Parent/Caregiver:

Thank you for selecting our agency for visitation services. This intake packet includes descriptions of our policies, procedures, and the roles of all parties involved in the services we provide. During your intake with Tania Glenn & Associates staff, please ask any and all questions you might have so that we can ensure a safe and productive experience.

Included in this intake packet:

- * Basic Information Sheet: This includes your general contact information as well as the name of your child(ren), emergency contacts, attorneys, guardian ad litem's, and any other involved parties.
- * Vehicle Information Sheet: We request that you provide information regarding all vehicles that may be used for visitation as well as a copy of your Driver's License or photo ID.
- * Fee Schedule for Services: This page explains all the costs associated with the services we provide including supervised visitation (on and off-site), therapeutic visitation, and court testimony. In addition it lists fees for copies of records, letters, financial statements, and penalties for cancellations, no-shows and late pick-up/drop-off.
- * Financial Policy: This page outlines who is responsible for what costs associated with our services, forms of payment accepted and our policies for non-payment and collections.
- * Release of Information: You will be asked to complete and sign this for EACH individual that you would like us to be able to share information with including verbal communications and copies of our supervision documentation. This would include attorneys, ad litems, parent coordinators, parent facilitators, therapists, caseworkers, etc.
- * Roles and Responsibilities for Supervised Visitation/Therapeutic Visitation: While you may be coming to our agency to receive one service, we often have families move from one level of service to another so this document covers the roles, responsibilities and expectations of parents/caregivers, Tania Glenn & Associates staff, and involved third parties during the visitation process.
- * Inclement Weather Policy: This provides an overall guide regarding how serious weather may impact your visit/exchange.
- * Signature Page: This page will require you to initial each section and sign indicating that each topic has been covered and you fully understand and agree to comply with all guidelines, policy, procedure, and expectations. This page also includes a place for your assigned monitor's contact information as well as the name and contact information for the Director should you have any questions or need to reach them outside the normal times of your exchanges/visitations.
- * You will be provided with a copy of the Fee Schedule, Financial Policy, Roles & Responsibilities, Inclement Weather Policy, and Signature Page at the end of the intake meeting.

Basic Information Sheet



Client Information:

Name: _____ Date of birth: _____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Cell Phone: _____ Home Phone: _____

Work Phone: _____ ext: _____ Email: _____

Involved Children:

| NAME | DATE OF BIRTH | GENDER |
|------|---------------|--------|
| | | |
| | | |
| | | |
| | | |

Emergency Contact Information:

Name: _____ Relationship to you: _____

Phone number(s): _____

Address (including city, state, zip): _____

Lawyer's Information:

Name: _____ Email: _____

Address: _____ Phone Number: _____

Guardian Ad Litem Information:

Name: _____ Email: _____

Address: _____ Phone Number: _____

Parent Coordinator / Parent Facilitator Information:

Name: _____ Email: _____

Address: _____ Phone Number: _____



Name on Driver's License, State or Military Identification Card

License/Identification Number Issuing State Expiration Date

Please provide your driver's license, State/ Military Identification Card or other valid photo identification card to TGA representative to copy for the file.

Please list all vehicles that may be used for visit or exchange purposes

Make and Color #1 Year Model State/License Plate Number

Make and Color #2 Year Model State/License Plate Number

Make and Color #3 Year Model State/License Plate Number



Financial Policy

Dr. Tania Glenn & Associates, PA

Dr. Tania Glenn & Associates, PA are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the office is designed to clarify the payment policies as determined by the management of the office.

The Person Responsible for Payment of Account is required to sign the form, *Payment Contract for Services*, which explains the fees and collection policies of the office. The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collection. A 1% per month interest rate is charged for accounts over 60 days.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan or payment at the time of service.

Missed appointments or cancellations less than 48 hours prior to the appointment, regardless of reason for cancellation are charged for the full visit time scheduled and payable by the individual late canceling or no/late showing. Please be mindful of traffic to ensure on time arrival. *DRO does not pay for missed or late cancel visits.

Payment methods include credit card (Visa or MasterCard only) or cash. Personal checks are not accepted.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: _____

Co-responsible party: _____ Date: _____



Fee Schedule for Private Pay Clients

All fees are regardless of income:

| Supervised Visitation | Therapeutic Visitation |
|----------------------------|----------------------------|
| 1-2 children \$60 per hour | 1-2 children \$70 per hour |
| 3-4 children \$75 per hour | 3-4 children \$85 per hour |
| 5+ children \$90 per hour | 5+ children \$100 per hour |
| \$25 per parent intake fee | \$50 per parent intake fee |

Additional Fees

Court Testimony: \$200.00 per hour (\$600 nonrefundable deposit plus subpoena required).

Late Return/Pick up Fees: \$10 for the first minute and \$5 for every subsequent minute that the parent is late for child return or pick up, unless agreed upon before the visit.

Copies/Scans of File: First 5 pages are free, each page after is \$1 per page. The person/party requesting the copies are responsible for the fees.

Letter outlining visits is \$30.00.

DEFINITIONS:

Supervised Visitation: This service provides contact between a Non-Custodial Parent and one or more children in the presence of a third person responsible for observing and seeking to ensure the safety of those involved. “Monitored Visitation” or “Supervised Child Access” are other terms with the same meaning.

Therapeutic Visitation: This service combines the functions of observing contacts between adult(s) and child(ren), seeking to provide safety and therapeutic intervention, shall be provided only by a mental health professional licensed by the State of Texas. Providers may offer internship programs leading toward a mental health professional license or certificate. Interns shall be under the direct supervision of a licensed or certified mental health professional.

Client: Any parent/caregiver engaged in supervision services by voluntary or court-ordered agreement.

Monitor: The Tania Glenn & Associates (TG&A) staff member who is assigned to provide supervision services.

Director of Supervised Services: The TG&A staff that supervises assigned Monitors.

RESPONSIBILITIES OF THE MONITOR:

- * The key role of the Monitor is to supervise visits according to court orders or other relevant agreements.
- * The Monitor shall relay information between the clients relevant to the child's welfare at the commencement and conclusion of the supervised visit (i.e. medication, diet, illness, etc.). The Monitor shall be able to do this both in writing and verbally to and from clients.
- * The Monitor shall be able to intervene when appropriate to seek to ensure the safety and welfare of the child(ren).
- * The Monitor shall terminate a supervised visit when necessary.
- * The Monitor shall provide feedback or correction to clients as needed.
- * The Monitor will document supervised visits as required and provide copies of

that documentation based on referral/funding source, court order, or signed releases of information.

CLIENT RESPONSIBILITIES PRIOR TO VISITATION:

- * Fully read, understand, and abide by TG&A guidelines and ask any/all questions you may have. You will be provided copies of all these guidelines and all associated fees.
- * Sign releases of information for GAL/attorney/any involved 3rd party and understand that no information can be shared with anyone without that with the exception of the DRO office or a court-order/subpoena.
 - * NOTE: DRO funded cases includes that notes will be sent to the GAL/DRO office after each visit.
- * Inform Monitor of all relevant history, issues, and concerns related to the case as well as any changes as the case progresses.
- * Understand the Monitor cannot give opinions on the case or discuss the other parent/caregiver(s) with you.
- * Provide all legal documents relevant to the services including court order, mediated agreement, etc.
- * Provide Monitor with current contact information and the best way to communicate (i.e. email, text, phone, etc.).
- * Make payments before the visit and understand that additional visits will not be scheduled if a balance is outstanding. Payments can be made in cash or by credit card. Personal checks are not accepted.
- * Custodial parent /guardian should not enter the parking lot until the exact time the visit is set to take place. And is to leave the area during visit and not return to area until exact ending time of visitation. There is no waiting in parking lot or waiting room.
- * Visiting parent /guardian is to arrive 15 minutes prior to visitation time. If the visiting parent is more than 5 minutes, the visit will be cancelled and payment will still be due by visiting parent. All vehicle occupants must accompany

visiting parent into the building (if approved) or leave the area until 15 minutes after the visitation conclusion time. At the end of the visit, the visiting parent will remain in the room for 15 minutes and until the monitor escorts him/her out of the building and is responsible for all clean up.

* Cancel any scheduled visits at least 48 hours in advance or be subject to cancellation fees. The only exception to these penalties are cases of medical emergency with supporting documentation from a healthcare professional and/or weather emergency as outlined in the TG&A Weather Policy.

CLIENT RESPONSIBILITIES DURING VISITATIONS:

- * Do not use drugs/alcohol before or during visits. Suspected use may result in termination of the service. Court orders may require/allow TG&A staff to drug screen/test on-site.
- * Do not bring weapons or dangerous items of any kind to a visit.
- * Discuss any plans to bring media-based activities to visit (i.e. movies, video games, etc.) and do not bring content that is not rated for your child(ren)'s age.
- * Bring all things necessary for visits (food, cups/plates, toys) based on the length of the visit and the age/developmental stage of your child(ren).
- * Plan all aspects of the visit (i.e. food, activities, supplies, etc.) again taking into consideration your child(ren)'s age, developmental stage, activity level, needs, and the visitation space.
- * Do not bring additional visitors to the visit without prior approval by the monitor. Additional visitors MUST be approved in writing in advance by all parties.
- * No pets are permitted.
- * Do not threaten violence or violation of court order during a visit, including during the transitions before and after the visit.
- * No client may commit any violent act or violate any court order during a supervised visit including the transitions before and after the visit.
- * Use the restroom before your child(ren) arrive for the visit to maximize your time

with them.

- * Use your visits to spend time with your children, maintain your relationship, and enjoy them. Do not use it to vent your anger, turn them against their other parent/caregiver, or involve them in adult issues related to your case.
- * Put your child(ren)'s needs first and understand if monitor has to end the visit early.
- * Do not try to secretly communicate with child during visit (i.e. whispering, passing notes, speaking in another language not spoken by the monitor, etc.).
- * Do not make any negative comments to a visiting child about the other client, his/her partners or family members.
- * Focus on bonding time and the child and avoid all discussions of the other parent and the legal aspects of the case.
- * Set appropriate limits for your child regarding rough play, aggressive physical behavior, loud or abusive behavior, discussion of inappropriate pics of conversation.
- * Model appropriate behaviors and language for your child(ren).
- * Use appropriate discipline interventions during the visit - corporal punishment or any physical discipline (hitting, shaking, slapping, pinching, etc.) is not allowed while time out, discussion, verbal redirection are recommended. Ask your monitor for assistance if needed.
- * Respect the visitation space including ensuring your child(ren) don't damage property, everything is put back after a visit, and all trash is in the trash can.
- * In cases with an active protective order, you MAY NOT take photographs or make audio or visual recordings on or off-site during visitation without prior approval of the child, the other client, and TG&A staff, or court order.
- * For off-site visits, you must provide the exact proposed location and understand the limitations of off-site visits (locations, activities). The monitor must be able to hear/see everything during visits. Understand that off-site visits must be

approved by Monitor, Director and involved 3rd parties before they can be scheduled.

CLIENT / MONITOR INTERACTIONS:

- * Do not challenge Monitor or disrespect Monitor in front of your child(ren).
- * Do not use the Monitor as a therapist to vent about the other parent/caregiver.
- * Do not use Monitor to relay messages or pass things to other parent/caregiver including support payments or legal documents.
- * Use the visitation time to engage the child(ren) and not chat with the Monitor.
- * Address concerns/complaints with the Monitor outside of the time with the child.
- * If you have issues with your assigned Monitor and have tried to communicate directly with them without resolution, contact the Director of Supervised Services.
- * Do not take pictures of or audio/video record Monitors before/during/after service provision.
- * Keep Monitor informed of any changes in the legal aspects of the case including providing copies of updated court orders, mediated agreements, etc.
- * We cannot enforce visitation. Contact your lawyer or GAL if problems arise with enforcement.**

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Dr. Tania Glenn & Associates, PA is authorized by me to use or disclose my Protected Health Information for a purpose other than for treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Dr. Glenn or her designated employee(s) to disclose my Protected Health Information as described on this form to the recipient listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

My entire mental health record

(Note: This requires an explanation of why it is necessary to disclose the entire record)

My demographic information (*check all that apply*):

Name Address State/Zip Code only Telephone

Age Gender Race Other:

Mental Health Data/Information as related to:

Specific condition(s):

Specific professional service(s):

Specific medication(s):

Other:

Psychotherapy Notes

Other: _____

Please disclose/discuss the above information to:

Name: _____ Telephone: _____

Address: _____

Purpose(s) for disclosure of the information: (Note: if the client is requesting disclosure, the purpose may simply state: "Client is requesting disclosure.")

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance to this authorization. In order for the revocation to be effective, Dr. Glenn must receive the revocation in writing, and the revocation must include:

- My name, address, and patient number, if applicable.
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization.
- My desire to revoke this authorization
- The date of the revocation and my signature

Should I wish to access my Protected Health Information, such request must be made in writing. I also agree that such access may be provided in summary form. I will provide all reasonable copying, postage, and preparation costs.

This authorization shall expire upon disclosure of the information specified to be released in this authorization. After this date, Dr. Glenn can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Signature of Client or Client's Representative

Date

Name of Client

Client Identification Number

Name of Representative (if applicable)

Description of Representative's Authority to Act

For Office Use Only

[] Authorization added to client's record on _____

[] Client has been provided with a copy of the signed authorization

TGA 8/1/14

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Dr. Tania Glenn & Associates, PA is authorized by me to use or disclose my Protected Health Information for a purpose other than for treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Dr. Glenn or her designated employee(s) to disclose my Protected Health Information as described on this form to the recipient listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

My entire mental health record

(Note: This requires an explanation of why it is necessary to disclose the entire record)

My demographic information (*check all that apply*):

Name Address State/Zip Code only Telephone

Age Gender Race Other:

Mental Health Data/Information as related to:

Specific condition(s):

Specific professional service(s):

Specific medication(s):

Other:

Psychotherapy Notes

Other: _____

Please disclose/discuss the above information to:

Name: _____ Telephone: _____

Address: _____

Purpose(s) for disclosure of the information: (Note: if the client is requesting disclosure, the purpose may simply state: "Client is requesting disclosure.")

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance to this authorization. In order for the revocation to be effective, Dr. Glenn must receive the revocation in writing, and the revocation must include:

- My name, address, and patient number, if applicable.
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization.
- My desire to revoke this authorization
- The date of the revocation and my signature

Should I wish to access my Protected Health Information, such request must be made in writing. I also agree that such access may be provided in summary form. I will provide all reasonable copying, postage, and preparation costs.

This authorization shall expire upon disclosure of the information specified to be released in this authorization. After this date, Dr. Glenn can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Signature of Client or Client's Representative

Date

Name of Client

Client Identification Number

Name of Representative (if applicable)

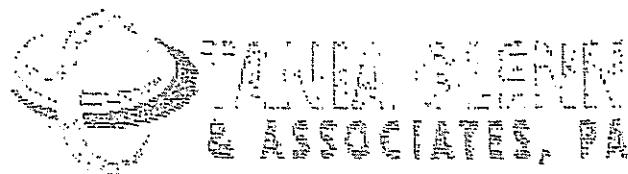
Description of Representative's Authority to Act

For Office Use Only

[] Authorization added to client's record on _____

[] Client has been provided with a copy of the signed authorization

TGA 8/1/14



4412 Spicewood Springs Rd., Suite 701
Austin, TX 78759
512-323-6994 (office)
512-323-9490 (fax)

TGA – Policy notification 1/28/14

Re: Inclement Weather

Please be advised that all supervised visitations and neutral exchanges will be automatically canceled with no penalty incurred if the following conditions are present:

Monday through Friday: Schools and/or government offices are closed.

Saturday and Sunday, and all Holidays: If the news encourages non-essential people to remain home and discourages travel unless necessary.

*Visits and exchanges can be rescheduled for the first following day these conditions do not exist.

Therapeutic Visitation Intake



Name: _____

Visiting Parent Custodial Parent

Name of TG&A Staff Conducting Intake: _____ Date: _____

Referral Source: _____

Why do you need therapeutic visitation arrangements at this time?

Please list all other Agencies and Parties involved (Get releases of information signed):

Have you previously had therapeutic and/or supervised visitation arrangements? If so, what were they? With whom? When? Why were they discontinued?

Please describe any issues in your case that has involved the personal safety of you or others in your family? (i.e. kidnapping, family violence, CPS involvement, police involvement, substance abuse, self-injury, homicidal threats, child/elderly abuse)

Therapeutic Visitation Intake



Please list your psychological history to include mental health diagnosis and treatment as well as substance abuse treatment (i.e. SI/HI, psychosis, inpatient):

What concerns do you have that might arise during visits or exchanges with the children?

What special requests do you have for restrictions during visitation? **Note: to enforce a No Photo request it must be noted in the court order and not all requests may be enforceable by TG&A Staff

Photos Videos Phones Calls (to whom?) _____
 Clothing Gifts Activities

Please list specifics: _____

Does your child have guidelines regarding the following?

food allergies medications toilet training
 ratings on TV/video games feeding

Therapeutic Visitation Intake



Please list specifics: _____

Details for visitation (where, when, with whom, for how long):

*****REQUEST COPIES OF ANY WRITTEN DOCS LISTED BELOW

Court ordered: _____

Mediated agreement: _____

Agreement between the parties: _____

Dictated by GAL or 3rd party:

What are your expectations for therapeutic visitation?

What are your parenting strengths? (List separately for each child if different)

**What are areas that are challenging to you as a parent (situational or overall)?
(List these separately for each child if different)**

Therapeutic Visitation Intake

What are your goals? (May be different goals for each child)

What are the goals of the child (if of an age that can verbalize this)?

What are the concerns (if any) of the child?

What additional information was provided by collateral sources for whom you have signed release?

SIGNATURE PAGE

The Roles and Responsibilities – Supervised Visitation/Therapeutic Visitation _____

Fee Schedule for Services _____

Financial Policy _____

Inclement Weather Policy _____

Assigned Monitor _____

Contact Number _____

Director _____

Contact Number _____

My initials and signature indicates the above topics have been fully explained and I fully understand and agree to comply with all guidelines, policy, procedures, and expectations. A copy of these documents have been provided.

Parent/Guardian _____ **Date** _____

TGA Representative _____ **Date** _____



**BlueCross BlueShield
of Texas**

Premium Bills - Bill Summary

Bill Profile: 0000376592 - ALL SUBSCRIBERS
Bill Period: 03/01/2015-04/01/2015 **Rebill:** NO **ProcessDate:** 02/13/2015

Bill Summary

Payments and Adjustments

| Date | Activity | Amount Due |
|---------------------------------------|--------------------------|--------------------------|
| Previous Amount Billed | | \$950.54 |
| Payments | | |
| 01/30/2015 | Online Bill Payment | (\$950.54) |
| Adjustments | | |
| | NONE | \$0.00 |
| Total Payments and Adjustments | | (\$950.54) |
| | Remaining Balance | \$0.00 |
| Fees | | |
| | Activity | Amount Due |
| | Current Employee Charges | \$950.54 |
| | Employee Fee Adjustments | \$0.00 |
| | Total Fees | \$950.54 |
| Payment Due Date | 03/01/2015 | Total Amount Due* |
| | | \$950.54 |

Next Auto Payment: 02/26/2015

*Total Amount Due includes the effects of Health Insurer and Reinsurance fees, plus any federal and state taxes applicable to these fees.

Allocated Taxes and Fees: \$33.22

Important Notice for Customers with HMO or PPO Products

Timely Notification to Cancel Membership is Required

Under Texas law, BCBSTX, as your insurer, is required to bill and collect premium for any cancelled member through the end of the month in which you notify us that a member is ineligible for coverage under your group plan. This means that you:

Must review each month's billing for any membership discrepancies.

Are required to continue to pay premium for all members, including terminated members, through the end of the month in which your cancellation(s) are reported to BCBSTX.

Should immediately report member cancellations. The preferred and quickest way to do this is online using BlueAccess® for Employers (BAE).

For more information on Timely Notification Requirements and the significant impact for you and your employees, visit
http://www.bcbstx.com/employer/timely_notification_requirements.htm