CENTER FOR COUNSELING & FAMILY RELATIONSHIPS

4500 Mercantile Plaza Dr. Ste. 307, Fort Worth, TX 76137

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We are happy to provide the benefit of filing PRIMARY INSURANCE ONLY for our clients. The following information needs to be completed before the initial appointment. If benefits have not been checked before the initial appointment, the client will be responsible for paying the full contract rate for their insurance company.

Primary Insured Information:

Name: _____

Address _____ City/State _____ Zip_____

Date of Birth: _____

SS# (must complete to file insurance)_____

Employer: _____

MENTAL HEALTH BENEFITS ARE DIFFERENT FROM MEDICAL BENEFITS

Insurance Company: _____

Mental Health Company (if different): _____

Phone #: _____ Person you spoke to: _____

Do you have a deductible? _____ How Much? _____Is it met? _____

Co-pay amount or % you have to pay? _____

Number of visits allowed per year: _____

Do you need a pre-cert or authorization number? _____ Number: _____

Start Date: _____End Date: _____Total # of sessions authorized: _____

New Client Information

Date ___/___/___

Client Name _____ M F Date of Birth: _____

Address _____City/State _____ Zip_____

Social Sec. # _____ (must complete to file insurance)

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Email Address: _____

Select Box:

Minor Single Married Divorced Separated Widow Living Together

Date of marriage: _____ (or) Date of living arrangement: _____

Do you want your counselor to incorporate faith/spiritual issues into your counseling? _____

Name of church attending: _____

School (if a student):_____ Years of Education: _____

Employer: _____Years with employer: _____

How did you hear about us? _____

If Client is a Minor:

Legal guardian's name:_____Phone Number: _____

Address: _____City/State: _____ Zip: _____

If your child no longer resides with both biological parents due to a divorce or change in guardianship, please bring the legal paperwork regarding custody and guardianship information relating to who is able to seek medical/psychological attention. **Custody/guardianship paperwork is required before a minor can be seen in a counseling session**.

Household Information: (List all who reside in the home)

Name	Role (Spouse, partner, girlfriend, boyfriend, child, step-child etc)	Date of Birth
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____

MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____

Please list any prescription medication you currently use: (Name, dosage, frequency)

_____

Please list any over-the-counter medications you currently use: (Name, dosage, frequency)

_____

Please list any past or present conditions that you are or have been treated for:_____

_____

Describe any medical or psychiatric conditions of your parents or siblings: _____

_____

How much exercise are you getting? _____

How many hours are you sleeping? _____

Cancellation Policy and Account Balance for Non-Medicaid Clients

It is our policy to charge a $75.00 fee for appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on our voice mail, which will note the day & time you called. For Monday appointments, cancellations can be left on our voicemail on the weekend 24 hours in advance. Your communication with our office about appointment cancellations allows us to offer that time to someone else who needs to be seen.

I authorize Center for Counseling and Family Relationships to keep my signature on file and to charge my credit card account for the following:

1. Balances of charges not paid within 30 days, but not to exceed $300.00.
2. Cancellation fee if an appointment is not cancelled within 24 hours.
3. If my card is declined for a no-show fee, I understand that the fee must be paid within 1 week or all future appointments I have scheduled will be cancelled.

I authorize balances for charges not paid within 90 days to be sent to a collections agency.
We do not accept American Express.

Cardholder Name: _____

Type of Card: _____

Account Number: _____

Expiration Date: _____CVV number:_____

Signed: _____ Date: _____

No-Show Policy for Medicaid Clients

We selectively accept a limited amount of Medicaid Insurance from specific referral sources for children who are in the process of being adopted or have recently been adopted. For all other clients, our office charges a $75.00 fee for all appointments that are not cancelled at least 24 hours in advance. Because we are unable to bill Medicaid or our clients using Medicaid for No-Show appointments, we provide referral sources to pursue counseling from another provider once a No-Show occurs.

Signed: _____ Date: _____

Our Fee Policy

To help control costs, we ask our patients to pay for their office visit at the time the service is rendered. For balances on an account, the client is required to pay the full amount before the client can resume counseling unless an alternate payment plan has been agreed upon.

Signed: _____ Date: _____

Assignment of Benefits

I authorize all insurance payments to be made to the designated provider or Center for Counseling and Family Relationships. This assignment will remain in effect until revoked by me in writing. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my insurance company, or any balance due after payments by my insurance company. It is the patient's responsibility to provide our office with the correct insurance information in order to file claims with the insurance company. Claims not paid due to incorrect information will then become the patient's responsibility.

If you are more than 15 minutes late for your appointment, you will be responsible for the $75.00 fee for the session, which is not reimbursable by insurance. I understand that I am financially responsible to Center for Counseling and Family Relationships for the charges incurred by myself and/or my dependents.

Not filing insurance (you do not have to sign this segment)

Signed: _____ Date: _____

Other Fees

1. **If report preparation is requested** or required, the time rate charged for therapy sessions will apply.
2. **Review of Provided Documents:** Documents related to history, background information, school behavior, or testing are billed at the rate of $2.00 per minute.
3. **Phone Calls:** Only emergency phone calls are returned on a regular basis and only during office hours. These are billed at $2.00 per minute & will be due at your next session. Review of Provided Documents and Phone Calls are not reimbursable by insurance.
4. **Professional Fees:** Court appearances, depositions, and attorney consultations are $150.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer deposit of $1500.00 is to be paid in advance of (and clear the bank) prior to the court date. If the full amount of the retainer/deposit is not needed to complete the court testifying process, then the remainder of the funds will be refunded. If the costs for the court testifying process exceed the amount of the retainer/deposit then those fees will be immediately billed to you and are due upon receipt of the invoice.
   The party issuing the subpoena is responsible for the testifying fees.

NOTE: *Even though you are responsible for the testimony fee, it does not mean that testimony will be solely in your favor. Only the facts of the cases and professional opinion of your counselor can be testified.*

5. Returned checks: There is a $25.00 charge on all returned checks.

Signed: _____ Date: _____

Grievances

I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

To report a rules violation by this licensee, contact the appropriate Board:

- Texas State Board of Examiners of Licensed Professional Counselors
- Texas State Board of Examiners of Marriage and Family Therapists
- Texas State Board of Social Work Examiners

At the following common address:

P.O. Box 141369
Austin, TX 78714-1369 (1-800-942-5540)

Signed: _____ Date: _____

Emergencies

For after hours emergencies, call 911 or Contact Hotline at (817) 335-3022 – Tarrant. This hotline is available 24 hours a day and is free.

Limits of Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

- child abuse
- abuse of the elderly or disabled
- abuse of patients in mental health facilities
- sexual exploitation
- criminal prosecutions
- child custody cases
- suits in which the mental health of a party is in issue
- situations where therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose (fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board.)

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this consent, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing you mental health care services and payment for those services, and you are also releasing and holding harmless the therapist from any departure

from your right of confidentiality that may result. **I also give permission for my counselor to converse with other counselors in the group practice to provide the best possible treatment for myself.**
I have read and understood the above limits to confidentiality.

Signed: _____ Date: _____

Acknowledgment of Review of Notice of Privacy Practices

I understand I have a right to review **Center for Counseling and Family Relationships** (henceforth referred to as **CCFR**) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (henceforth referred to as **PHI**) that will occur in my treatment, payment of my bills and the rights I have regarding my **PHI**. I consent to the use or disclosure of my **PHI** for these purposes.

I understand I have the right to request a restriction as to how my **PHI** is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **CCFR** is not required to agree to the restrictions that I may request. However, if **CCFR** agrees to a restriction that I request, the restriction is binding on **CCFR** and my counselor. I also understand that if these restrictions limit the ability of my insurance to pay, I will be held responsible for the entire fee up front.

I have the right to revoke this consent, in writing, at any time, except to the extent that my counselor or **CCFR** has already taken action based on this consent.

The Notice of Privacy Practices for **CCFR** is provided upon request. **CCFR** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____ _____

Printed Name of Patient of Personal Representative **Patient's Name if Minor**

_____ _____

Signature of Patient or Personal Representative **Date**

Communication Authorization and Release of Information to Family Members

Do we, Center for Counseling and Family Relationships, have permission to:

- Leave a message on your home answering machine regarding an appointment? ☐ YES ☐ NO
- Contact you at work regarding appointment changes, etc? ☐ YES ☐ NO
- Contact you by email regarding your appointment or bill? ☐ YES ☐ NO
- Discuss your appointment times with your spouse/parent/partner? ☐ YES ☐ NO

I acknowledge that confidentiality may not be maintained if text, e-mail or a cell phone is used pertaining to my Protected Health Information.

_____ _____

Printed Name of Patient of Personal Representative **Patient's Name if Minor**

_____ _____

Signature of Patient or Personal Representative **Date**

☐ I understand that checking this box constitutes all legal signatures confirming that I acknowledge and agree to all the above items listed.