



CENTER FOR COUNSELING & FAMILY RELATIONSHIPS

4500 Mercantile Plaza Dr. Ste. 307 Fort Worth, TX 76137
Metro: 817-232-9400 Fax: 817-232-9403
office@ccfam.com www.ccfam.com

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 contracted rate for their insurance company.

PRIMARY INSURED’S INFORMATION

Name: _____ Relationship to Client: _____

Address: _____

Date of Birth: _____ SS# (must complete to file insurance): _____ - _____ - _____

Insured’s 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? YES NO How Much? _____ Is it met? YES NO

Co-pay amount or % you must 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: _____

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.

Please check box if you are Not filing insurance (you do not have to sign this segment if not filing)

Signed: _____ Date: _____



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NEW CLIENT INFORMATION

(Please Print)

Date ___ / ___ / ___

Client Name _____ M/ F Date of Birth: _____

Address _____ City/St _____ Zip _____

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

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

Email Address _____

(Circle One)

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 _____

Emergency Contact Person: _____ Number: _____ Relationship: _____

How did you hear about us? _____

IF CLIENT IS A MINOR:

Legal guardian's name _____ Phone # _____

Address _____ City/St _____ 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, stepchild etc.)	Date of Birth
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____



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MEDICAL HISTORY

Primary Care Physician: _____ Phone # _____

Other prescribing Physician(s):

Name _____ Specialty _____ Phone # _____

Name _____ Specialty _____ Phone _____

List any psychotropic/mental health medications you currently use: (Name, dosage, frequency)

List prescription medication(s) you currently use for medical issues: (Name, dosage, frequency)

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

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 of sleep are you getting? _____

How would you rate your diet? Poor Fair Good Excellent

How much caffeine do you consume in a day? _____

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 or Personal Representative

Patient's Name if Minor

Signature of Patient or Personal Representative

Date



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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:** _____

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.

Signed: _____ **Date:** _____



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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:** _____

**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. Copay or deductible for TeleHealth appointments.
2. Balances of charges not paid within 30 days, but not to exceed \$300.00.
3. Cancellation fee if an appointment is not cancelled within 24 hours or if No Show Appointment.
4. 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.

(Please Print)

Cardholder Name: _____ Type of Card: _____

Billing Address for Card: _____

City/St: _____ Zip: _____

WE DO NOT ACCEPT AMERICAN EXPRESS

Credit Card Number: _____

Expiration Date: _____

Signed: _____ **Date:** _____

OTHER FEES

1. Form completion or summary request to other professionals: \$35.00
2. Records Requests to other professionals: \$35.00 plus .59 per page.
3. Phone Calls to other professionals: \$1.00 per minute
4. Personal Records Request by a client or guardian: \$55.00. plus .59 per page.

Please note that when records are requested to be used personally, clients or client family members can no longer be seen in our office. Referrals will be given to continue counseling at another practice. CCFAM follows this policy to uphold the highest quality therapeutic relationship and security of confidentiality with all of its clients.



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Please also note that we do not specialize in high conflict divorce cases and these cases will receive trusted referrals.

5. 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 courthouse 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.

6. Returned Checks: There is a \$25.00 charge on all returned checks.

Signed: _____ **Date:** _____

NO-SHOW AND LATE CANCELLATION POLICY

Clients who have to no-show for any reason or late cancel with less than 24 hours' notice will be charged a 75.00 fee. The No-Show will be charged to the card on file the following business day after a client has been notified of their No-Show appointment. If the charge does not go through for the card on file, the client will be notified that the balance must be paid within 7 days or all future appointments will be cancelled.

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 clients using these benefits for No-Show appointments, we provide referral sources to pursue counseling from another provider once a No-Show occurs.

Signed: _____ **Date:** _____

NO-SHOW POLICY FOR NEW DIRECTIONS EAP CLIENTS

We accept benefits from New Directions EAP. 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 New Directions EAP or our clients using these benefits for No-Show appointments, we will no longer bill future sessions with the EAP after a No-Show occurs. Clients can choose to continue counseling using their managed care benefits.

Signed: _____ **Date:** _____