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 https://ccfam.com

FIRST APPOINTMENT CHECKLIST

If you are filling out the New Client Forms online, all required sections must be completed, and IDs uploaded before the paperwork is submitted. After submission, you will receive a confirmation email.

All of these items **must be brought** to the initial counseling session or the appointment will have to be rescheduled.

For All Clients:

☐ First Appointment Checklist
☐ Completed Intake Paperwork
☐ Driver's License or ID (from client or biological/custodial parent of a minor)
The licensing boards in Texas require for us to verify your identity at your initial counseling session.
☐ Completed Electronic Media Recording Client Release Form
☐ Completed Consent to Treatment
☐ Completed Additional Paperwork Forms – If Applicable to Client:
* Child Intake Form for All Children below the age of 18 to be filled out by parents
* Client History for Middle School and High School Students to be filled out by students
*Adult Intake Form
*Adoption Information Form/Foster Care Information Form

For Minor Clients:

☐ Divorce Decree or Custody Paperwork
☐ I acknowledge that a Divorce Decree or Custody Paperwork has not been filed by the courts for this minor. Signature _____
☐ **Please also note that we do not specialize in high conflict or pending court cases. These cases will receive trusted referrals.**

For Adult, Couples, and Parent Appointments for Minor Clients:

☐ We want you to get the most out of your session times with us. Please arrange for childcare for any child over the age of 11 months. If children over 11 months are brought to a scheduled appointment, the appointment will be charged as a No-Show appointment and rescheduled. We also require **children under the age of 7 to be supervised in the wait room.**

Signature: _____

For Clients Filing Insurance for Sessions:

☐ Insurance Card (if filing with insurance)

If EAP benefits are being used, the insurance card is still required.

☐ Check Insurance Benefits by calling insurance and completing questions on Page 3 of Intake Paperwork. If benefits are not checked, the client will be asked to pay the full contract rate for the initial session.

For All Clients to Acknowledge go to our website https://ccfam.com:

☐ Review Policies and Procedures

☐ Review Privacy Practices

IN ADDITION:

☐ Credit Card Information is completed on Page 7. ***This is a requirement for our office***.

The alternative is to pay $100 in advance at the first appointment to stay as a credit on the account. The session time is reserved for you. For our counselors to continue to be able to provide care for you and your family through our practice, they also must be able to provide a dependable income for their families.

☐ Initiate Portal Account by clicking on the link sent to e-mail

The link lasts for 7 days after it is sent. Please check spam for this link.

The portal account allows you to view future appointments.

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 https://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 $100.00 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:** _____

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 https://ccfam.com

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 _____

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.**

Communication Authorization

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

- Leave a message/text on your given phone number regarding services? **YES NO**
- Contact you by email regarding services? **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.

Revoking your permission:

You may change your mind and withdraw your permission for communication authorizations at any time, without any penalty or loss of care of services. To revoke your permission, an opt-out form can be given at your request.

_____

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

_____

Signature of Patient or Personal Representative **Date**

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 https://ccfam.com

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**. National Hotline: **988.** All hotline numbers are available 24 hours a day and are free.

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:** _____

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.

Please also note that we do not specialize in high conflict or pending court cases. 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.

Please note that 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

It is our policy to charge a $100.00 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.

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.

Signed: _____ **Date:** _____

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 https://ccfam.com

NO-SHOW POLICY FOR MEDICAID CLIENTS

We selectively accept a limited number of minor clients who have Medicaid and are in the process of being adopted or have recently been adopted. For Medicaid clients, our office policy for No-Shows is different than that for other clients. For Medicaid clients, we are unable to charge the No-Show fee or bill Medicaid. If a No-Show occurs, we instead provide referral sources to pursue counseling from another provider outside of this office.

Signed: _____ **Date:** _____

NO-SHOW POLICY FOR NEW DIRECTIONS EAP CLIENTS

If you have been approved under a New Directions EAP, our office policy for No-Shows is different than that for other clients. For New Directions EAP clients, we are unable to charge the No-Show fee or bill New Directions. If a No-Show occurs, you would no longer be able to continue counseling using the EAP but could choose to continue under insurance (if applicable) or self-pay.

Signed: _____ **Date:** _____

ACCOUNT BALANCE AND CREDITS

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.

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 my card is declined for a No-Show fee, I understand that the fee must be paid within one week or all future appointments I have scheduled will be cancelled.

We issue credits in the form of a check to clients a month after the client has completed counseling and all insurance payments have been received. Credits include overpayments on a client's account, as well as cash that was placed on file for no-show appointments.

(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:** _____

ACKNOWLEDGEMENT 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 **CCFAM**) 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. **CCFAM** is not required to agree to the restrictions that I may request. However, if **CCFAM** agrees to a restriction that I request, the restriction is binding on **CCFAM** 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 **CCFAM** has already acted based on this consent.

The Notice of Privacy Practices for **CCFAM** is on our website (lower right corner). **CCFAM** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

_____

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

_____

Signature of Patient or Personal Representative **Date**

GRIEVANCES

The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology.

Although not every complaint against or dispute with a license involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Please call 1-800-821-3205 for more information.

Signed: _____ **Date:** _____

POLICIES & PROCEDURES

We want to welcome you to our office and thank you for choosing our practice to meet your counseling needs. As we start our counseling relationship together, all of our counselors want to make sure that we have informed you of what to expect in your time with our practice.

SESSION TIMES:

Session times are reserved for you. Unlike primary care physician's offices with multiple clients every 15 minutes, our counselors set aside 53 minutes to meet with you in your session and reschedule for future appointments. The last 3 minutes of each session is used to reschedule with the counselor.

NO-SHOWS, LATE CANCELLATIONS & SCHEDULING:

It is important that you understand and agree to our No-Show Policy. Our counselors have devoted their career to helping others. For them to be able to support themselves and their families, they depend on their income from their session times. Just as it would be a hardship for your family if your employer were unable to guarantee how much you could depend on making each paycheck, our counselors depend on the income that is generated by the session times.

For this reason, clients who No-Show for any reason or late cancel with less than 24 hours notice will be charged a $100.00 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 my card is declined for a No-Show fee, I understand that the fee must be paid within one week or all future appointments I have scheduled will be cancelled.

Appointment scheduling, rescheduling, or cancelling **is not accepted through client portals or through e-mail**. Please call the office and leave a message if you reach our voicemail. To avoid the late cancellation fee with more than 24 hours notice, you may leave notice of cancellation on our voicemail at any time, which will note the day & time you called. Please give the reason for cancellation on the voicemail. For Monday appointments, cancellations can be left on our voicemail on the weekend 24 hours in advance.

No-Show Policy for Medicaid Clients

We selectively accept 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 $100.00 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.

LATE ARRIVAL & SCHEDULING:
If you are more than 15 minutes late for your appointment, you will be responsible for the $100.00 fee for the session, which is not reimbursable by insurance.

ACCOUNT BALANCES & CREDITS:

- The credit card on file is to be used for:
  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.

- To help control costs we ask our patients to pay their office visits at the time service is rendered.

For balances on an account, the full amount is due before the client can resume counseling.

- We issue credits in the form of a check to clients a month after the client has completed

counseling and all insurance payments have been received. Credits include overpayments on a client's account, as well as cash that was placed on file for no-show appointments.

SCHOOL & WORK NOTES:
School and work notes are also available at the time of rescheduling.

EMAILS:
For counselors working with children, a message through the portal is required before each session that is attended by the child individually. Messages need to be received by the morning of the child's appointment.

RELEASE OF INFORMATION:
We require releases to be signed before any information regarding a client is released whether verbally or written from our office to any physician, school personnel, etc.

WAIT LIST PROCEDURES:
New and current clients can ask to be put on the wait list for their counselor. When a cancellation occurs, clients are texted and the first client to accept the appointment is the one to receive the appointment. An offer of an appointment through a text does not guarantee that the opening will still be available when the call is returned to our office. A client's name is not put in the scheduler until the client has called to confirm the appointment.

EMERGENCIES:
For after-hours emergencies, **call 911** or Contact Hotline at **(817) 335-3022 – Tarrant**.
National Hotline: **988.** All hotline numbers are available 24 hours a day and are free.

CONTINUED CARE:

I understand the following fully:

- After two consecutive missed appointments without 24 hour cancellation notice, the client will be given referrals for further treatment at other counseling facilities and will be considered an inactive patient.

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.)

CONSENT TO TREATMENT

I, voluntarily, agree to receive Mental health assessment, care, treament, or services, and Authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services And that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.

By signing the New Client Information forms and the Consent to Treatment form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained. Many opportunities have been offered for me to ask questions and seek clarification of anything unclear to me.

Print Name of Client_____

Signature of Client
_____ or

Signature Parent/Legal
Representative_____

Date:_____

Counselor Name:_____

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 https://ccfam.com

VIDEO AND ELECTRONIC MEDIA RECORDING CLIENT RELEASE FORM

I, _____give my consent to record audio and video of my counseling sessions and have those recordings securely stored on electronic media. I acknowledge that I will be informed prior to any recordings of my counseling and understand electronic recordings will be used for solely for counselor supervision at the Center for Counseling and Family Relationships.

Your Rights:

You have the right to have the electronic recording stop at any time. Giving permission for us to use these items is voluntary. Your treatment, payment, enrollment and eligibility or benefits do not depend on allowing media recording of your sessions. You may request an opt-out form to revoke this consent without any penalty or loss of care or services. If you have any questions about your rights, you can speak to your counselor regarding your concerns.

Revoking your permission:

You may change your mind and withdraw your permission for use of electronic recording at any time, without any penalty or loss of care of services. To revoke your permission, an opt-out form can be given at your request.

Expiration:

Unless otherwise revoked, I understand that this authorization will expire when the electronic media is no longer useful to the education or mission of the Center for Counseling and Family Relationships, at which time the information will be destroyed.

HIPAA guidelines will be followed for the professional use and appropriate protection of and disposal of recorded material.

_____

Printed Name of Client OR Parent/Guardian, if client is under 18 years of age

Date:_____

_____

Signature of Client OR Parent/Guardian, if client is under 18 years of age.