

## CLIENT INFORMATION

Name: \_\_\_\_\_

Phone: (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we send billing statements or any other mailings to the above address?

Yes  No, please use the following address:

\_\_\_\_\_  
\_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Marital Status \_\_\_\_\_

Others living at home: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you work: Full-time \_\_\_\_\_ Part-Time \_\_\_\_\_ Educational level: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

List any significant health problems: \_\_\_\_\_

\_\_\_\_\_

List any medications you are taking and the dosage: \_\_\_\_\_

\_\_\_\_\_

Have you seen a counselor or psychotherapist before?  Yes  No

If yes, when and with whom? \_\_\_\_\_

What did you seek counseling for? \_\_\_\_\_

How were you referred to my office? \_\_\_\_\_

May I thank him or her for referring you?  Yes  No

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## CLIENT SERVICES CONTRACT

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between us.

### COUNSELING SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches that can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems. But there are no guarantees about what will happen.

By the end of the evaluation, your therapist will be able to offer you some initial impressions of what the work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your selected therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your therapist's procedures, please feel free to discuss them whenever they arise. If your doubts persist, we will be happy to help you to secure an appropriate consultation with another mental health professional.

### MEETINGS

Our normal practice is to conduct an evaluation that will last from 2 to 4 sessions. During this time, you and your therapist can decide together whether he/she is the best person to provide the services that you need in order to meet your treatment objectives. If psychotherapy is initiated, we will usually schedule one forty-five to fifty-minute session (one appointment hour of 45-50 minutes duration) per week at a mutually agreed time, although sometimes sessions will be longer or more frequent.

### PROFESSIONAL FEES

The regular hourly rate for psychotherapy services is \$125. In addition to weekly appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations that last longer than 5 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries or the time required to perform any other service that you may request of me. In unusual circumstances, you may become involved in a litigation that may require your therapist's participation. You will be expected to pay for the professional time even if he/she is compelled to testify by another party.

### APPOINTMENT SCHEDULING AND CANCELLATION

Cancellation of scheduled appointments is required 24 hours in advance. If you do not appear for a scheduled appointment, you will be charged the full hourly fee of \$125.00, unless you provide 24 hours advance notice of cancellation [or unless we both agree that you were unable to attend due to circumstances beyond your control].

If you do not appear for a scheduled appointment, you will be charged the full hourly fee for two reasons:

- 1) We maintain a waiting list of clients who require appointments. If you cancel 24 hours in advance, we will be able to fill your appointment with another client.
- 2) Insurance companies do not reimburse therapists or clients for missed appointments; therefore you will be liable for our full fee, not your standard co-pay amount.

### BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested.

If you did not pay at the time of service and your account is more than 60 days in arrears, a service charge of 1.5% of the balance per month will be charged to your account. If your account is more than 60 days past due and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that

proceeding will be included in the claim. In most cases, the only information that is release about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

## **INSURANCE REIMBURSEMENT**

If your therapist is a network provider with your mental health insurance carrier, our office will submit claims for payment on your behalf. You are responsible for any co-payments, co-insurance, and deductibles required by your health plan.

If your therapist is not a network provider with your mental health insurance carrier, our office will assist you by completing our portion of a claim form. You are responsible for completing your portion as well as mailing it to the insurance company and tracking your reimbursement. We do not accept assignment of benefits from insurance carriers whose panels we are not affiliated with. Your therapist will gladly discuss your proposed treatment with your insurance company *if they call us* and you provide us with a signed release. *We will not call to request authorizations.* You are responsible for the full fee regardless of your insurance company's reimbursement policies.

## **CONFIDENTIALITY**

In general, the confidentiality of all communications between a client and a licensed professional counselor is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a number of exceptions.

In some judicial proceedings, you may have the right to prevent information about your treatment being provided. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your therapist would be legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment:

- If he/she believes that a child, an elderly person, or a disabled person is being abused, he/she must file a report with the appropriate state agency.
- If he/she believes that a client is threatening serious bodily harm to another, he/she is required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
- If a client threatens to harm him/herself, he/she may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

Should such situations occur, your therapist would make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of his/her client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless he/she feels that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have with your therapist at your next meeting. As you might suspect, the laws governing these issues are quite complex and your therapist is not an attorney. While he/she will be happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your therapist will provide you with relevant portions or summaries of the applicable state laws governing these issues.

## **CONTACTING YOUR THERAPIST**

Your therapist is often not immediately available by telephone. Anytime you need to speak to your therapist, you may call our main line at 713-533-9811. During business hours you may either leave a message with our office manager, or you may leave a voicemail message. If you call outside of business hours, you will be able to leave a confidential voicemail message for your therapist. Listen carefully to the message to ensure you are selecting the correct voicemail box for your therapist. Please note that voicemail messages will result in your therapist being paged. If you cannot reach your therapist, and you feel that you cannot wait for your call to be returned, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a trusted colleague whom you can contact if necessary.

**PROFESSIONAL RECORDS**

Both law and the standards of my profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records at our discretion, but if you wish, your therapist can prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/or can be upsetting. If you wish to see your records, we recommend that you review them in your therapist’s presence so that you may discuss what they contain. Clients will be charged an appropriate fee for any preparation time required to comply with an information request.

**MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they consent to give up access to your records. If they agree, your therapist will provide them only with general information on how your treatment is proceeding unless he/she feels that there is a high risk that you will seriously harm yourself or another, in which case, your parents will be notified. Your parents will also be provided a summary of your treatment when it is complete. Before giving them any information, your therapist will discuss the matter with you and will do the best he/she can to resolve any objections you may have about what has been prepared to discuss.

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I, \_\_\_\_\_, have read and agree to the conditions of this contract.  
Print full name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FEE AGREEMENT**

Check **one** of the following statements:

\_\_\_ I am covered by mental health insurance for which my selected therapist is an in-network provider. I understand that he/she will seek reimbursement from my mental health insurance carrier and will track reimbursement. I hereby authorize the release of any information necessary to process health insurance claims and assign payment of such benefits to my selected therapist.

\_\_\_ I am covered by mental health insurance for which my selected therapist is an out-of-network provider, will be seeking reimbursement for services, and am requesting services at the regular hourly rate. I understand that my therapist or his/her office manager will complete the provider’s portion of a health insurance claim form at least once every four visits and at my request and will provide such form to me. If for any reason I have not paid in full for services received, I hereby authorize the release of any information necessary to process the necessary health insurance claim and assign payment of such benefits to my selected therapist.

\_\_\_ My visit was arranged and will be paid for by one of the following third parties:  
• IBC Bank  
• Other \_\_\_\_\_

\_\_\_ I do not have insurance covering mental health treatment.

\_\_\_ I am covered by mental health insurance but, at my option, choose not to seek reimbursement for services. I understand that I will be receiving services from my therapist at the full hourly rate or at the negotiated rate of \_\_\_\_\_.

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I understand that the regular hourly rate for psychotherapy services is \$125.00. I agree to pay the hourly or negotiated rate for any professional services performed (as outlined under PROFESSIONAL FEES on page 1 of the Client Services Contract) during the course of my treatment. If my treatment is covered by my mental health insurance, I agree to pay my portion of the fees for service as outlined by my insurance company.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date