

Assignment of Benefits:

I authorize all insurance payments to be made to the designated provider or **CCFAM** and/or **CTFW**. The assignment will remain in effect until revoked by me in writing. I understand that this order does not relieve me or my obligation to pay such bills if not paid by my insurance company, or any balance due after payments by my insurance company.

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

◇ **Insured Name:** _____

◇ **Address of Insured:** _____

◇ **Date of Birth:** _____

◇ **Social Security # (required to file insurance)** _____

◇ **Employer:** _____

◇ **Do you have a deductible?** YES NO **How much?** _____ **Is it met?** YES NO

◇ **Co-pay amount or % you have to pay:** _____

◇ **Number of visits allowed per year:** _____

◇ **Pre-certification/ Authorization #:** _____

Start Date: _____ **End Date:** _____

◇ **Total # sessions Authorized:** _____

◇ **Claims Address of Mental Health Provider** _____

Signed: _____ **Date:** _____

Communication Authorization and Release of Information to Family Members

Do we, **Center for Counseling and Family Relationships** and/or **Center for Psychological Testing**, 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

Printed Name of Patient or Personal Representative

Patient's Name if Minor

Signature of Patient or Personal

Date

Description of Personal Representative's Authority (parent, guardian, etc.)

Our Fee Policy

To help control costs we ask our patients to pay their office visits at the time service is rendered. I understand that I am financially responsible to **Center for Counseling and Family Relationships** (hence forth referred to as **CCFAM**) and/or **Center for Testing of Fort Worth** (hence forth referred to as **CTFW**), for the charges incurred by myself and/or my dependents

Signed: _____ **Date:** _____

Cancellation Police and Account Balance

It is our policy to charge a \$50.00 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. Your communication with our office about appointment cancellations allows us to offer that time to someone else who needs to be seen.

I authorize **CCFAM** and/or **CTFW** to keep my signature on file and to charge my credit card account listed below 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.

Account Number: _____

Expiration Date: _____

Signed: _____ **Date:** _____

Other Fees:

1. Initial intake assessment and reporting of assessment results appointments are 45-50 minutes long. If you are more than 15 minutes late for your appointment, you will be responsible for the \$50.00 fee for the session.

2. 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 \$900.00 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.

3. Returned Checks: There is a \$35.00 charge on all returned checks.

Signed: _____ **Date:** _____

Guidelines for Continued Care:

I understand the following fully:

- 1. The patient will only be considered an active patient of **CCFAM** and/or **CTFW** if the patient keeps each appointment made.
- 2. After the passage of 6 months without contact between **CCFAM** and/or **CTFW** and the patient, the patient will automatically be considered to be an inactive patient
- 3. Inactive status may be instituted if bills are not paid in a timely fashion.

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:

Texas State Board of Examiners of Licensed Professional Counselors
1100 W. 49th Street Austin, Texas 78756-3138 (512) 834-6658

Client or Parent/Guardian Signature **Date**

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **CCFAM** and/or **CTFW** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **CCFAM** and/or **CTFW**. I understand that diagnosis or treatment of me by my counselor may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. **CCFAM** and/or **CTFW** is not required to agree to the restrictions that I may request. However, if **CCFAM** and/or **CTFW** agrees to a restriction that I request, the restriction is binding on **CCFAM** and/or **CTFW** and my counselor.

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

My “protected health information” means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house.

This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I realize that it may be necessary for my counselor to converse with other counselors in the group practice to provide the best possible treatment for myself.

The limits to confidentiality in the state of Texas are:

- 1. Threatening to take one’s life/suicide**
- 2. Threatening to take someone else’s life/homicide**
- 3. Records/notes being subpoenaed by an attorney/court.**
- 4. Abuse to a child or elderly**
- 5. If my therapist receives supervision and/or consultation in order to provide me with the best quality care.**
- 6. If the therapy & or evaluation is court ordered.**

Client or Parent/Guardian Signature

Date

Special Note

If my counselor becomes incapacitated or dies, I give my consent for the person designated by them to become the custodian of my file and to access it for me. I understand I have a right to review **CCFAM** and/or **CTFW's** 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 that will occur in my treatment, payment of my bills or in the performance of health care operations of **CCFAM** and/or **CTFW**.

The Notice of Privacy Practices for **CCFAM** and/or **CTFW** is provided upon request. This Notice of Privacy Practices also describes my rights and the **CCFAM** and/or **CTFW's** duties with respect to my protected health information. **CCFAM** and/or **CTFW** 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 by sent in the mail, or by requesting one at the time of my next appointment.

Printed Name of Patient or Personal Representative

Patient's Name if Minor

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (parent, guardian, etc.)

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review a copy of **CCFAM** and/or **CTFW's** 'Notice of Privacy Practices'. This notice describes how this office may use and disclose my protected health information, certain restrictions that apply regarding the use and disclosure of my healthcare information, and the rights I have regarding my protected health information.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (parent, guardian, etc.)