Date: _____

Client's Full Name:_____**Date of Birth**:_____**Gender**: _____

Address:_____**City:**_____**State:**_____**Zip:** _____

Name of Legal Guardian* (if minor): _____

**If client is a minor, please complete the following*:*

Parents' Marital Status (check one): ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who has legal/physical custody? _____

Please provide legal documentation, if necessary, for the information above (custody).

*Please be advised that **prior** to the start of counseling services to a minor client counselors/therapists shall obtain and review a current copy of the custody agreement or court order, as well as any applicable part of the divorce decree.*

Cell Phone:_____**Alt. Phone:**_____OK to leave a message? ☐Yes ☐No

Email:_____Ok to contact by email re: billing/scheduling concerns? ☐Yes ☐No

Who would you like us to contact in case of an emergency**?** (*First & Last Name*) _____

Emergency Contact Phone Number:_____Relationship to client? _____

May we contact your primary care physician to coordinate care? ☐Yes ☐No

If yes, what is the name and phone number of your physician? _____

Insurance Information (*If applicable*)

Are you: ☐ Primary Policyholder ☐Dependent

Primary Insurance Information

Primary Insurance Company Name: Insurance ID #: _____

_____ Group #: _____

Policy Holder's Name: Policy Holder's Birth Date:_____/_____/ _____

_____ Social Security Number: _____/_____/_____

Policy Holder's Employer:_____Relationship to Policy Holder: _____

Do you have a secondary insurance? ☐Yes ☐No

Are you: ☐ Primary Policyholder ☐Dependent

Secondary Insurance Information

Secondary Insurance Company Name: Insurance ID #: _____

_____ Group #: _____

Policy Holder's Name: Policy Holder's Birth Date:_____/_____/

_____ _____

Policy Holder's Employer:_____ Relationship to Policy Holder: _____

Current Areas of Concern:

Please rate how the issue(s) below are affecting the following areas of your life.

1= No Effect to Seldom Effect **2= Moderate Effect** **3= Significant Effect**

Depression/Mood Swings		Alcohol/Drug Use	
Anxiety/Stress		Family Member's Alcohol/Drug Use	
Self-Doubt, Guilt, Shame		Sexual Functioning	
Marriage/Partner Relationship		Eating Habits	
Family Conflict		Sleeping Habits	
Job/School Performance		Physical/Chronic Health	
Ability to control anger		Family Member's Anger	
Friendships/Social Functioning		Ability to Concentrate	

How did you hear about us? *Please check all that apply.*

☐ **Physician**_____ ☐ **Friend**_____ ☐ **Facebook**
name *name*

☐ **Search Engine**_____ ☐ **Other** _____
(Please specify)

Consent Forms

Name of Client:_____Client D.O.B.: _____

Welcome to our practice and thank you for entrusting us with your care. At Living Tree New Braunfels Counseling Center, PLLC (LTNB) we provide psychotherapy services to children, adolescents, and adults. Our clinicians are licensed to provide behavioral health services by the state of Texas. This document contains important information about our professional services and business policies. To avoid misunderstandings, it is important that you read these policies carefully and ask for clarification when needed. After reading this sign and date this form.

WHAT TO EXPECT: Our first few sessions will involve an evaluation of your needs. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once counseling has begun, we will usually schedule weekly or bi-weekly sessions. If, at any time, you feel dissatisfied with our sessions, please let me know, so we can discuss your needs and modify our approach as needed or direct you to alternate resources that may be helpful. We would like to offer support and guidance in all the phases of our work together, including when you decide to leave counseling. Ending treatment will work best if you give several weeks' notice prior to actually leaving. The notice allows you to highlight your progress, review useful concepts and tools, and have a positive experience of completion.

FEES & PAYMENTS	
Initial Intake Interview (Evaluation)	$200.00
Individual Therapy Session	$200.00
Family & Couples Therapy Session	$200.00
Private Pay discount	$125.00
Late Cancellation Fee	$50.00
Returned Check Fee	$25.00
Sliding scale (For clinical associates only)	LPCA/LMFTA's offer $90 couples, family and individual
Court/Legal Appearances- *(Please refer to Court/Legal Appearances section for details)*	A retainer of $1500 is due in advance.

_____**Co-Payment and/or payment of services are due at the time of service**. We accept checks, payable to "Living Tree New Braunfels Counseling Center, PLLC," cash and major credit cards including MasterCard, Visa, Discover, American Express & Flex/HSA Cards. We may file your insurance for you, but it is your responsibility to know what your portion of payment is. Receipts for our services are made upon request. Please note that during the course of therapy, it may become necessary to increase fees to compensate for our overhead expenses. The practice requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges. *(Please type/print your initials in the box)*

_____I have read and understand that my insurance (if using insurance) may or may not cover the full session fees as described above, accept financial responsibility, & agree to be timely (within 10 days of notice) in making payment arrangements if this is necessary. *(Please type/print your initials in the box)*

INSURANCE: If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, LTNBCC will assist you as a courtesy to the extent possible in filing claims and ascertaining information about your coverage, ***but you are responsible for knowing your coverage and for letting LTNBCC know if/when your coverage changes.***

You should also be aware that most insurance companies require you to authorize LTNB to provide them with a clinical diagnosis. Sometimes we may have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that LTNB can provide requested information to your carrier if you plan to pay with insurance, including diagnosis and treatment provided.

_____If you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash, or credit card. *(Please type/print your initials on the line above)*

In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers and then you will be responsible for the fee. If you prefer to use a participating provider, wecan provide a referral for you.

_____I understand and consent to the release of information for the purposes of filing insurance claims and I understand that this information will include a diagnosis. I also understand that further information may be requested by the insurance company to make a determination regarding medical necessity. *(Please type/print your initials on the line above)*

CANCELLATION POLICY: Once an appointment is scheduled, that time is reserved exclusively for you. If you are unable to make the appointment, please provide at least 24-hour notice so that you will not be charged the $50.00 cancellation fee and that time can be made available to someone else. We will waive that fee in the case of emergencies (death in the family, contagious illness, unsafe driving conditions). Please note that we will not make exceptions for situations such as lack of babysitter, forgotten appointment or a sudden business meeting or time conflict.

_____I have read and understand that missed appointments or appointments not canceled at least 24 hours in advance will be charged the $50.00 fee (excluding Medicaid). (*Please type/print your initials in the box).*

CONTACTING THE OFFICE:

Office Phone: (281) 925 – 7780 / Fax: (210) 783 - 1646
Addresses: 1067 FM 306 Ste 402 & 607 New Braunfels, TX 78130
Email: Livingtreecounselingnb@gmail.com
Website: www.livingtreenb.com

_____Please note that email and text messages are not a secure form of communication and should not be used to discuss important issues that would best be discussed directly during our sessions. Please keep

email and text correspondence limited to scheduling and administrative purposes. (*Please type/print your initials in the box).*

If we are unavailable for your immediate attention, please leave a message on our voicemail and we will make every effort to return your call by the next business day. **For mental health emergencies, please call 911 or proceed to your local emergency room or closest hospital.** If your therapist will be unavailable for an extended period of time, we will notify you and provide therapeutic coverage with another LTNBCC clinician, as needed.

CONFIDENTIALITY: In general, the law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others with written permission, but please note the exceptions listed below:

1. If we have cause to suspect abuse and/or neglect of a minor child or an elderly or disabled adult, we are required to file a report with the appropriate state agency.
2. If we believe you present an imminent danger to the health and safety of yourself or another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.
3. In response to a court order or where otherwise required by law.
4. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend our practice.
5. To the extent necessary for emergency medical care to be rendered.
6. Finally, there are times when we find it beneficial to consult with colleagues as part of our practice for mutually professional consultation. The consultant is also legally bound to keep the information confidential.

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via a HIPAA compliant video conferencing software/program, telephone, email, text, or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. LTNBCC will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, we can arrange to encrypt email communication with you.

Please note that if you are also seeing another provider in the practice, we have the right to discuss pertinent information that you may disclose with that provider to coordinate the best possible care.

_____I have read and understand the exceptions to my confidentiality. *(Please type/print your initials in the box)*

PROFESSIONAL RECORDS: The laws and standards of our profession require that our clinicians (behavioral health practitioners) keep Protected Health Information (PHI) about you in your confidential clinical record. It includes information about your reasons for seeking therapy, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your

billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and your therapist believes that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your clinical record, if you request it in writing.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist or have them forwarded to another mental health professional so you can discuss the contents.

COURT/LEGAL APPEARANCES: Your clinician's role at LTNB is not intended to gather information for custody decisions, to determine parental capacity for the courts, or provide testimony in court cases. However, we understand that on rare occasions these situations may be unavoidable. If you anticipate needing court/legal appearances and would like a recommendation of someone who may be able to participate more easily, we can provide a referral to you.

_____ I agree that I will make every possible effort to avoid calling upon my therapist to provide treatment records or to testify in a future divorce, custody, or parental capacity action unless extenuating circumstances make such request unavoidable. *(Please type/print your initials on the line)*

_____ Should a court or legal appearance be required, the following fee schedule applies: As stated above in the "Fees & Payments" section, a retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer of $1500). Finally, all fees are doubled if the counselor had scheduled plans to go out of town; clinician will be compensated for their time at a rate of $120/hr., to begin when clinician leaves office, includes all travel time to and from appearance location, and includes all duration of time present at appearance location regardless of time clinician is an active participant in proceedings. A $500 deposit is required to obtain these services, to be paid in full on the date clinician agrees to participate. If the total cost including all portions of time aforementioned totals less than the $500 already paid for deposit, the remaining funds will be refunded back to client in the form of a check. If time spent exceeds the $500 deposit, client agrees to make payment in full on remaining balance within 3 business days of the clinician's appearance. *(Please type/print your initials on the line)*

_____ I understand that the outcome of the proceedings with my clinician's involvement does not alter the fee schedule in any way, and all monies are to be paid in full regardless of proceedings being ruled in my favor or the opposing party's favor. *(Please type/print your initials on the line)*

_____I understand that courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court. If such evaluation is required, your therapist can assist you in locating a clinician who is qualified to conduct such assessments. *(Please type/print your initials on the line).*

ACKNOWLEDGEMENT RE: NOTICE OF PRIVACY PRACTICES (NPP):

You may refuse to sign this acknowledgment:

On this date, I,_____ ☐received a copy of ☐ do not want a copy of Living Tree New Braunfels Counseling Center, PLLC's, "*Notice of Privacy Practices*" to protect the privacy of my health information. *(Please type/print your name on the line)*

_____I have been oriented regarding this notice and understand that I may ask for a copy of this notice at any time. I am aware that I may direct questions about our privacy practices to LTNBCC. *(Please type/print your initials on the line)*

ACKNOWLEDGEMENT REGARDING CLIENT'S RIGHTS AND RESPONSIBILITIES:
You may refuse to sign this acknowledgment:

I_____(client/parent/legally responsible person) give my consent for Living Tree New Braunfels Counseling Center, PLLC to provide assessment, treatment and/or other services for the above-named client. I reserve the right to withdraw consent at any time. I also reserve the right to refuse, at any time, any services offered to me. Additionally, in an emergency, I grant Living Tree New Braunfels Counseling Center, PLLC permission to seek emergency medical care from a hospital or physician. *(Please type/print your name on the line)*

COMPLAINTS: If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license (Texas Behavioral Health Executive Counsel 333 Guadalupe St, Suite 3-900, Austin, Texas 78701, phone 512-305-7700 or 1-800-821-3205 your insurance company (if applicable), or the US Department of Health and Human Services.

_____

Printed or Typed Name

_____ _____

Signature Date

_____ _____

Clinician Signature Date