

PERSONAL INFORMATION:

OFFICE USE ONLY

Today's Date: _____ Client Name: _____

CSLR: _____
DX: _____
FEE: _____
INS? _____

Address: _____

City / State / Zip: _____

Ok to send correspondence to this address? Yes / No

Home Phone: _____ Ok to leave a message here? Yes / No

Work Phone: _____ Ok to leave a message here? Yes / No

Cell Phone: _____ Ok to leave a message here? Yes / No

Email: _____ Ok to send email here? Yes / No

Birth Date: ___ / ___ / ___

Marital Status: _____ Married _____ Single _____ Divorced _____ Cohabiting

Employer: _____

Occupation: _____

Spouse and Children's names: _____

- How did you hear about I Choose Change? (Check all that apply)
- | | |
|---|---|
| <input type="checkbox"/> Living Magazine | <input type="checkbox"/> Community Paper |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Psychology Today |
| <input type="checkbox"/> Physician: _____ | <input type="checkbox"/> Friend: _____ |
| <input type="checkbox"/> Relative: _____ | <input type="checkbox"/> Other: _____ |

Would you like to receive emailed blog articles or information on upcoming events? Yes / No

INSURANCE INFORMATION (OPTIONAL):

NOTE: Cannot receive insurance reimbursement when seeing a Counselor Intern.

Insured Name: _____ Insured Birth Date: ___ / ___ / ___

Insured Employer: _____

Insurance Co.: _____ Group #: _____ ID#: _____

Insurance Payor ID #: _____

Insurance Phone No. (on back of card)

INITIAL FOR AUTHORIZATION:

- _____ 1. I give consent to **I Choose Change** to perform necessary procedures to diagnose, treat and care for the mental health needs for my child or me.
- _____ 2. I understand that all receipts will be emailed to the address above, but I can request a paper copy anytime.
- _____ 3. I understand that **I Choose Change** is an out-of-network provider who will submit for insurance reimbursement upon my request.
- _____ 4. Should I authorize **I Choose Change** to submit claims to my insurance company, I hereby authorize the release of any information relating to insurance claims, and I authorize payment of my group insurance benefits directly to **I Choose Change** which may be used as credit for upcoming appointments.
- _____ 5. I understand that my insurance company may pay less than the actual bill for services and that I am fully responsible for payment in full at the time of my appointment.

HIPAA Compliance:

The HIPAA notice describes how mental health information about you may be used and disclosed and how you can get access to this information. This Privacy Notice tells you about your rights about your mental health care records. You can look at this copy anytime to see what use is made of your health care records and who gets to see them. A new government rule requires that we give you this Privacy Notice to sign.

The HIPAA Compliance notice is posted in the I Choose Change waiting room and on the website. If you would like a hard copy of the HIPAA Compliance information or a copy of your paperwork, please let your counselor know and a copy will be provided for you. Please review it carefully.

Our policy has always been to keep your records safe. Your records are usually kept in a folder of papers with your name on it. Your records can also be stored in a computer. Your records tell what analysis and treatments you have had, and what decisions the counselor has made.

By signing below, you attest that you have read and have been made aware of your rights of confidentiality as a mental health consumer.

Client/Guardian Printed Name

Relationship to Patient

Client/Guardian Signed Name

Date Signed

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: We are Professional Counselors. Our formal education has prepared us to counsel individuals, groups, couples, parents and families.

Nature of Counseling: Our theory of counseling is that people have specific behaviors they would like to change, which are caused by our irrational, self-defeating beliefs learned early in the developmental cycle. These behaviors are brought to counseling in various forms of unhappiness in one's life. Our goal will be to assist with change of the irrational and self-defeating beliefs, so as to change undesired behaviors and circumstances. While we use various techniques and exercises to help aide the change process, we most closely subscribe to the foundation of Cognitive Behavioral Therapy (CBT) and Attachment Theory.

Types of Counseling: Counseling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology. *Face-to-face counseling* for individuals, couples, and groups involves synchronous interaction between and among counselors and clients using what is seen and heard in person to communicate. *Technology-assisted distance counseling* for individuals, couples, and groups involves the use of the telephone or the computer to enable counselors and clients to communicate at a distance when circumstances make this approach necessary or convenient.

CONSENT TO TREAT

Counseling Relationship: While we work together, usually we will meet weekly for approximately 45-50 minute sessions unless we mutually agree to different terms. Our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social or personal one. Please do not invite us to social gatherings, offer us gifts, ask us to write references for you, or ask us to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns.

Our in-person contact will be limited to counseling sessions you arrange with us. We schedule appointments based on availability and your need. If you experience a mental health emergency, obtain crisis services by dialing 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might be harmful.

We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors P.O. Box 141369, Austin, Texas 78714-1369 or by calling 1-800-942-5540 to obtain more information.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, we encourage you to sign a release so we may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with us, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with us and sign a release that enables us to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against our advice, we may consider this your decision to change counselors.

We also reserve the right to postpone and/or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, we reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Internet Counseling and Telephone Therapy: Distance counseling supplements face-to-face counseling by providing increased access to counseling on the basis of necessity or convenience. Barriers, such as being a long distance from counseling services, geographic separation of a couple, or limited physical mobility as a result of having a disability, can make it necessary to provide counseling at a distance. Internet counseling shall include e-mail-based individual counseling, chat-based Individual, couple or group counseling, and video-Based Individual, couple and group counseling.

Cancellation: In the event that you will not be able to keep an appointment, please notify us by telephone at least 24 hours in advance, whenever possible. *If this 24-hour notice is not respected, you will be billed for your session at the rate in which we discussed during your initial session.*

Referrals: We recognize that not all conditions presented by clients are appropriate for treatment with us. For this reason, you and/or we may believe that a referral is needed. In that case, we will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Session Fees*: Therapist fees range by licensure status and experience. Please see the enclosed fee schedule. Should fees ever be a hindrance to therapy, please discuss with your counselor and we will make every effort to work with you within our agency. If we are unable to help, we will find a counselor who better fits your financial needs.

Legal Fees*: We have no forensic experience and being master level therapists we would generally not be a good expert witness. However, in the event of court proceedings where we are court-ordered to appear, or our records are needed, our hourly fee is \$200 for any amount of work performed including copies, drive time, wait time, depositions and court proceedings.

*A 10% charge will be added to all outstanding balances, and all returned checks will incur a \$30 fee.

Records and Confidentiality: All of our communication becomes part of your clinical record. Adult client records are disposed of five years after the file is closed. Minor client records are disposed of five years after the client's 18th birthday. All of our communication is confidential, except in the following cases: a) We are using your case records for purposes of supervision, professional development and research. In such cases, to preserve confidentiality, we will identify you by first name only; b) We determine that you are a danger to yourself or someone else; c) You disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) You disclose sexual contact with another mental health professional; e) We are ordered by court order to disclose information (although we make every effort to shield information); f) You direct us to release your records; or g) We are otherwise required by law to disclose information. If we see you in public, we will protect your confidentiality by acknowledging you only if you approach us first.

In the case of marriage or family counseling, we will keep confidential (within limits cited above) anything you disclose to us without your family member's knowledge. However, we encourage open communication between family members and we reserve the right to terminate our counseling relationship if we judge the secret to be detrimental to the therapeutic progress.

While engaging in internet counseling, steps are taken on behalf to provide as much confidentiality as possible, but we wish to make clients aware of the potential hazards of unsecured communication. As such, we will take steps to verify your authenticity at every session. We use encryption methods whenever possible.

By signing below, you are indicating that you read and understood this statement (2 pages), or that any questions you had about this statement been answered to your satisfaction and that you were furnished a copy of this statement if requested (this information can also be located on our website).

Client or Guardian Signature

Date

Client or Guardian Signature

Date

SERVICE	TIME	THERAPIST	FEE
Individual, Couples, Family Counseling	50 minutes	Licensed Counselors / Therapists	\$110 - no insurance \$135 - insurance processing
Individual, Couples, Family Counseling	50 minutes	Counselor Intern*	\$85
Telephone, Video or Chat	1 hour	All Therapists	Same as above
Email Counseling	15-minute increments	All Therapists	\$20 per 15-minutes
Group Counseling	Varies by group	All Therapists	Varies by group
Phone Consultations	As needed	All Therapists	Prorated accordingly
Report Writing	1 hour	All Therapists	\$165
Legal Fees	1 hour	All Therapists	\$200

COUNSELING & COACHING PACKAGES:

BULK 5: Purchase 5 sessions in advance and receive a \$50 discount.

BULK 10: Purchase 10 sessions in advance and receive a \$100 discount.

PAYMENT INFORMATION:

How you be paying for your sessions? (Circle one)

Cash - Check - Visa - MasterCard - AMEX - Discover

If paying by credit card, please fill out the following:

Name on card: _____

Card number: _____

CVV Code: _____

Card Expiration: _____

Authorized Card Signer: _____

CANCELLATIONS:

24-hour notice is required for all cancellations. *If there is no notification of cancellation by phone (214-548-1318) in the 24-hour time frame, you will be billed for your session as normal.* This is to allow for those waiting for an appointment to have the opportunity to schedule an appointment. Your credit card will be billed automatically for phone consultations if another form of payment is not established at the time of service. By signing below, you agree to the terms listed and are aware of required fees for services.

Responsible Party Printed Name

Responsible Party Signature

INSURANCE REIMBURSEMENT:

If you'd like, we will be happy to submit your insurance for reimbursement in ANY insurance plan; however, we request you pay in full at the time of your session. Typically, insurance will provide between a 50% - 90% reimbursement, depending on your specific plan. Sessions with Counselor Interns not eligible.

Would you like I Choose Change to file for electronic reimbursement with your insurance provider? Yes / No
(If you circled yes, please submit insurance information at our website or on the first page of this packet.)