FACE SHEET

Initial Appointment Date: ____/____/_____

CLIENT INFORMATION

First Name: _____ Initial:____ Last Name:_____

Date of Birth:_____ Social Security No.:_____

Sex: _____ Marital Status: _____ How did you hear about us: _____

Address:_____ City:_____ Zip: _____

Employer or School:_____ Full Time___ Part Time___

Circle The Preferred Phone Number: Home (____)_____ Work (____)_____

Cell Phone: (____)_____ Email:_____ Religion:_____

PAYMENT INFORMATION (we will need a copy of <u>insurance card</u> and <u>photo ID</u>)

Full name of Insured:_____ DOB:_____ Sex: _____

SSN: _____ (*Insured person's social security number is <u>required</u>*)

Address of Insured: _____ City: _____Zip: _____

Client's relationship to insured (circle): Self Spouse Child Other:_____

Insured's Employer:_____

CIRCLE CONTACT PHONE OF YOUR CHOICE: Home Phone: (____)_____

Work Phone (____)_____ Cell Phone: (____)_____ Other: (____)_____

Is there a secondary insurance policy (circle) Yes No I don't know

EMERGENCY CONTACT:

Full Name:_____ Phone Number: (____)_____
Address:_____ Cell Phone: (____) _____
Relationship to client:_____

Full Name:_____ Phone Number: (____)_____
Address:_____ Cell Phone: (____) _____
Relationship to client:_____

CONFIDENTIAL CLIENT INFORMATION

Client Name: _____

Children or Siblings (name, ages): _____

_____

_____

_____

Are you currently receiving treatment for an illness, injury, or other medical condition? Yes No

If yes, what is the diagnosis and what are the treatments:_____

_____

_____

Are you currently taking any prescription or over-the-counter medications or illegal drugs? Yes No

If yes, please tell us the name and dosage of each medication:_____

_____

_____

Past Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, bankruptcy, juvenile delinquency):_____

_____

_____

What are your goals for therapy?_____

_____

_____

_____

The above information is true and correct to the best of my knowledge.

_____ _____ Circle: Self Parent Spouse Other

Signature of person completing this page | Date | Your relationship to client

PRE-AUTHORIZATION FOR HEALTH CARE

CONSENT FOR TREATMENT

By signing this document, I, _____, am indicating that I agree to participate in the following services with Chevone Franklin, LPC-Intern:

____	CLINICAL ASSESSMENT	____	INDIVIDUAL THERAPY
____	CLINICAL ASSESSMENT FOR MY CHILD	____	THERAPY FOR MY CHILD
____	FAMILY THERAPY OR COUPLE/RELATIONSHIP THERAPY	____	GROUP THERAPY
____	OTHER _____		

I understand that, in order to develop the therapist-patient relationship and treatment plan necessary to meet my needs, an initial assessment will be completed and a joint decision made to either proceed with the recommended treatment plan or to continue the assessment over additional visits. The limitations and benefits of all therapy or services I may receive will be discussed with me. I understand that while the long-term goal of therapy is to feel better, I may experience a period of feeling worse before I begin to feel better and I also understand that there is no guarantee of success. I understand that there may be alternative methods of therapy for my consideration and I am encouraged to ask questions regarding my treatment or other methods at any time.

PRIVACY (CONFIDENTIALITY) POLICY

State and federal laws protect the confidential nature of the therapist-client relationship. Clinical information will not be released to anyone without prior written consent to do so by the client (or the guardian-parent of a minor). However, there are some exceptions where information may be released without client consent. These include:

1) A therapist must take appropriate action when there is a danger to the client or to another individual at the client's hands. In general, this means that the therapist may involve others to protect the client if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival. Others may also be involved to prevent harm to another person. State law mandates that suspected neglect or abuse of a child, of an elderly individual, or of a disabled individual must be reported.
2) When ordered by a court to do so, a therapist may testify or release client records. However, no release of information or testimony is given in response to a subpoena without the client or client guardian's written authorization unless required by law to do so.
3) Consultation with other health care professionals may be necessary at some point in time. Where possible, identification of clients is withheld. However, there are times when exchange of information is necessary. An example of this type of exchange would be when the therapist is out of town or on vacation and another therapist is providing coverage for that therapist. Case material is often used for training, for research, and for other academic endeavors but client identification is always removed. Any other release of information must come with the above listed written approval.

I understand that this agreement is valid for the duration of time that I am participating in services with Chevone Franklin, LPC (hereinafter referred to as CF). By signing below, I acknowledge that I have received a copy of the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy*** and I understand and agree to the entire contents of those documents. I acknowledge that I have had an opportunity to have answered any questions, comments, or concerns that I might have had prior to signing this consent and participating in services. I am aware that I can stop counseling at any time. CF reserves the right to amend the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy*** and changes will be available at the office of CF. I can request a copy of changes at any time at no charge. Any changes that CF makes are effective immediately unless otherwise indicated. **A COPY OF THIS PAGE MAY BE FOUND ON THE LAST PAGE.**

_____ _____

CLIENT SIGNATURE (18 and older) Date

_____ _____

SIGNATURE OF PARENT OR SPOUSE Date
(for a child age 17 or younger

Notice of Financial Responsibility

Fees/Payments: I understand that I will be charged **$90** per session. Rates for other services will be arranged with Chevone Franklin in advance of such additional services. Furthermore, I understand that: **(1) I am responsible for payment at the time of the session. (2) If I do not give a 24-hour notice of a cancellation I may be charged up to the full session fee.**

I understand that payment may be made with cash, credit/debit card, or any other similar mode of electronic bank transfer. Chevone Franklin does not extend credit. If payment is not made when due, a late payment fee of $10 per month will be charged on any balance not paid within 30 days. Riverbend Counseling or CF does not depend on an outside collection service unless accounts are overdue by 90 days. Riverbend Counseling and CF would much rather communicate with patients and find solutions to overdue accounts. I hereby consent to the delegation of collection activities to an outside collection agency, including the release of necessary information required by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. There is a returned check processing fee of $40 in addition to reimbursement for charges assessed by the bank. I understand I cannot continue with sessions until outstanding balances are resolved.

Statements, receipts, or other documentation: Statements, receipts, or other documentation WILL NOT be issued to any delinquent account until paid in full. I agree that Riverbend Counseling and CF reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I will have 30 days to decide if I will continue services with CF under the amended agreement. I authorize payment of benefits to Riverbend Counseling or CF for any all services received.

COURT APPEARANCES: I understand that if report preparation is requested or required, the time rate charged for our therapy sessions will apply. Extended or frequent telephone contact will also be charged for. I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are $100 per hour including travel and waiting time are non-discountable and are payable in advance only. A four-hour minimum ($420) is required and must be paid prior to any testimony, provision of a clinical opinion, response to attorneys via telephone call or mail, subpoenas, or preparation of any report for litigating parties.

_____ _____

Signature of client or Parent of child under 17 Today's Date

CREDIT CARD INFORMATION AND AUTHORIZATION

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be charged at the full hourly rate, and this will not be covered by your insurance. If you are going to be late, please call me on my cell (210) 322-8279 or my office number (830-515-8480). If you arrive late, the session will still end at the scheduled time. If you have not called or arrived within the first 15 minutes of your appointment, you will be considered a "no show, no call" and you will be billed for the entire session cost.

Credit Card Authorization Form

I, _____, hereby authorize Riverbend Counseling or *Chevone Franklin, LPC* to bill my credit card as listed below for professional fees for [ ] myself or _____.

I agree that Riverbend Counseling or *Chevone Franklin, LPC* may bill my credit card at the full fee of $_____ for professional services including the following:

(Initial)
_____ Appointments that I elect to pay by credit card.
_____ Missed appointments. (Will be charged at the full fee)
_____ Appointments I have cancelled with less than 24 hours' notice. (Full fee)

I also agree that my credit card may be charged for the following:
_____ Balances of charges not paid by me .
_____ Insufficient funds/returned checks and bank charges for those.

Type of Card: (check one):

[ ] Visa [ ] Mastercard [ ] Discover [ ] American Express

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____

CVV2/CID Security Code: _____

Zip code on billing address: _____

Signature: _____

Date of Signature: _____

Charges will appear on your credit card statement as Riverbend Counseling, or *Chevone Franklin, LPC* or some variation of it.

Chevone Franklin, LPC may be contacted directly at 210-322-8279.

RELEASE OF INFORMATION:

Complete each applicable section

Section 1 - If you are utilizing medical insurance for billing

I authorize any, and all, of my medical information necessary to process insurance claims to be released to

_____ for the purpose of processing claims. This authorization to release information shall be valid through December 31,____.

_____ _____
Signature of client or Parent of child under 17 Today's Date

This authorization to release information shall be valid through December 31,_____.

Section 2 – Complete if you are authorizing CF to talk to someone other than Riverbend Counseling Center staff about your counseling sessions, . I.e., family member, doctor, clergy, etc.

(1) I authorize CF to talk to/collaborate with _____ about my counseling sessions. Do not discuss the following topics:_____

Can documents be sent to the individual/business if requested? Circle YES or NO

_____ _____
Signature of client or Parent of child under 17 Today's Date

(2) I authorize CF to talk to/collaborate with _____ about my counseling sessions. Do not discuss the following topics:_____

Can documents be sent to the individual/business if requested? Circle YES or NO

_____ _____
Signature of client or Parent of child under 17 Today's Date

(3) I authorize CF to talk to/collaborate with _____ about my counseling sessions. Do not discuss the following topics:_____

Can documents be sent to the individual/business if requested? Circle YES or NO

_____ _____
Signature of client or Parent of child under 17 Today's Date

This authorization will remain in effect for 90 days after end/termination of counseling services unless revoked sooner by client.

ABOUT CHEVONE FRANKLIN, MA., LPC

Please initial in/beside each box:

I understand that Chevone Franklin is a Licensed Professional Counselor in the state of Texas

I understand that Chevone Franklin works with children, adolescents, and adults in individual, group and family counseling.

I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to Chevone Franklin about this.

I understand that Chevone Franklin does not perform formal testing but refers individuals to those who do.

I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Chevone Franklin to tell someone else in writing or verbally, b) Chevone Franklin determines that her client poses a threat to themselves or others, c) she is ordered by a court to disclose information, or d) she suspects that child abuse has taken place, at which time she will notify Child Protective Services.

I understand that counseling can improve as well as upset the equilibrium in any person or family.

I understand that if I have a complaint that I cannot resolve with Chevone Franklin that I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540 to file a formal complaint.

I understand that there is a returned check fee of $40 and that if a returned check is not cleared up in 30 days, Chevone Franklin may file a suit with the Comal County District Attorney's Office.

I understand that all payments are due at the time of service.

I understand that if I do not give at least 24 hours notice in canceling an appointment, I will be charged a fee equal to that of the scheduled appointment. This amount will be due not later than the next scheduled appointment.

I understand that the rate for each session is $_____(fill in the amount).

I understand that Chevone Franklin is not a psychiatrist, she is a Masters' level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see an physician/psychiatrist for a medication evaluation.

Emergencies: I understand that although Chevone Franklin does not provide formal emergency services, she does wish to be available to the extent possible. I may call the office number or her direct cell at any time and leave a message. If during the business day, this call will be returned fairly, quickly in most circumstances. If the call is received over night or on the weekends, it will usually be returned the next day or business day. If I find myself in an urgent situation, I have the choice of waiting for the return call, of calling 911, or of going to the nearest emergency room for immediate care.
Chevone Franklin recommends I call 911 for immediate assistance if I am in a crisis situation.

Death or Incapacity: I understand that in the event Chevone Franklin dies or becomes unable to continue providing clinical services, Jay L. Jeter, LPC-S will be designated as conservator for my patient records and he will take possession of said records at that time; and upon receipt of my written request , Jay L. Jeter, LPC-S will make these records available to me or a mental health provider of my choice. Jay Jeter can be reached at Riverbend Counseling Center, 252 N. Union St., New Braunfels TX 78130 or at (830) 515-8279.

By signing below, I confirm that I have read, agree to, and received the above information.

_____ _____

Client/Parent of Client ***Date Received and Read***