New Braunfels Counseling
790 Generations Dr. Ste 410.
New Braunfels, TX 78130
(830)625-0599 fax (830)625-5877

Jennifer Mitchell, PsyD

CLIENT CONTACT FORM

Date:_____

Please Print Clearly

Client Name:_____ Date of Birth: _____ Age: _____

Gender: Male/ Female/Other Marital Status: M S D Social Security:_____

Address: _____

City, State, Zip: _____

Circle the preferred:

Home Phone: (____)_____ Cell Phone: (___)_____

May I leave a message? YES NO Restrictions: _____

Email address: _____ PCP: _____

Employer: _____ How did you hear about us?_____

Family/Emergency Contact Data

Parent/Spouse/ Guardian: _____

Address: _____ City, State, Zip: _____

Parent/ Spouse Employer: _____ Phone: (___)_____

Parent/ Spouse Social Security Number: _____ DOB: _____

Name of nearest relative not living with you: _____

Address: _____ City, State, Zip: _____

Phone: (____)_____

Description of Problem:

_____

_____

_____

_____

_____

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Payment /Therapy Charges

We will need a copy of your insurance card and photo ID

Insured Full Name: _____ DOB: _____ Sex: _____

SSN: _____ *(Insured person's social security is required)*

Address of Insured: _____ City/State/Zip: _____

Client's relationship to insured: **Self Spouse Child** Other: _____

Insured's Employer: _____

Insured's Phone: (____) _____ *(circle)* **cell home other**

Is there a second insurance policy *(circle)* **YES NO** *(if yes a copy of the card is required and ask office staff for an additional form for insurance)*

Therapy Charges

Initial Evaluation		**Individual/Family/Group Therapy**	
45 to 60 min.	$200.00	45 min	$150.00 (individual)
		60 min	$180.00 (individual)
		45/60 min	$180.00 (family)

I hereby give New Braunfels Counseling Center permission to file with my insurance company to receive reimbursement for services rendered. I understand that I am totally liable for my bill and although NBCC will file with my insurance, I am liable for charges accrued while I am receiving therapeutic services. **Missed appointments, and those cancelled with less than 24 hours notice will be billed to me at the standard rate. If more than two consecutive therapy sessions are NO SHOW's, the account must be made current before any additional sessions will be scheduled.** I acknowledge I will need to speak with my provider before additional sessions will be scheduled. I ACKNOWLEDGE THAT I HAVE BEEN ADVISED ON THE NOTICE OF PRIVACY PRACTICES explaining how my medical information will be used and disclosed. I may request a copy for my records free of charge at any time.

Patient (parent/guardian if minor) Signature: _____

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Informed Consent

By signing this document, I, _____, am indicating that I agree to participate in the following services with New Braunfels Counseling Center (hereafter NBCC):

_____ CLINICAL ASSESSMENT
_____ CLINICAL ASSESSMENT FOR MY CHILD
_____ FAMILY THERAPY OR COUPLES THERAPY
_____ OTHER _____
_____ INDIVIDUAL THERAPY
_____ THERAPY FOR MY CHILD
_____ PSYCHOLOGICAL TESTING

I understand in order to develop the therapist-patient relationship 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 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.

Notice of Privacy Practices

I ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES (HIPPA): (PROVIDED UPON REQUEST) _____ Notice of Privacy Practices received (initial)

_____ Notice of Privacy Practices declined (initial)

Signature: _____ Date: _____

Relationship to Client: _____

Client Responsibilities

As a patient, you have some important responsibilities. Please keep all scheduled appointments with your provider and be prompt. Being on time is an indication of your commitment to your own progress in therapy. Please remember that once an appointment is made, your provider has set that time aside. Late cancellations or “No Shows” not only disrupt your provider’s schedule, but are discourteous as well. If some occurrence prevents you from keeping a scheduled appointment, contact the office as soon as possible. You will be charged the standard rate for a full session if you miss a session (if 24 hours notice is not given to cancel your appointment). ***The 24 hour notice must be during the Monday through Friday work week, not over a weekend or the standard fee will be charged to you (not insurance).*** If the initial appointment is a NO SHOW, a fee of $50 will be charged once paperwork is completed to reserve the rescheduled initial appointment. The fee will be applied to the cost of the initial session. If insurance is used, the fee will be applied to the copay or coinsurance after the session is billed to the insurance company. If there is no fee associated with the insurance, the amount will be refundable. We also reserve the right to terminate services if there are excessive cancellations or “No Shows” as the client is not likely to benefit from treatment.

Phone Messages

If a situation arises that you feel the provider needs to know about before your next scheduled appointment, please feel free to contact the office and leave a message for your provider. Your message will be confidential, and your therapist will review your message before your scheduled session. There will be a fee of $180.00 per hour for phone support, prorated in 15 minute increments. If an emergency arises, please contact 911 or go to the nearest emergency room.

Financial Responsibility

We accept most insurance and will file your claim for you; however, it is important for you to understand that you are responsible for your bill. We expect payment of any deductibles and/or copayments as services are rendered. Payment may be made by cash, check, debit and credit card in the office. Flexible spending account /HRA cards are also accepted.

NBCC does not extend credit. NBCC would rather communicate with our client’s to find solutions to overdue accounts. I will contact the office if payment arrangements need to be made. I hereby consent to the delegation of collection activity to an outside collection service, including the release of necessary information by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required.

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I am aware that there is a **returned check fee of $25** in addition to the reimbursement of the charges assessed by NBCC's bank. ***Statements, receipts, or other documents will not be issued to any delinquent account until paid in full.*** Payment by credit cards will be in accordance with the Informed Consent form provided by NBCC. I agree that NBCC reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I have 30 days to decide to continue treatment with my provider at NBCC under the amended agreement. I authorize payment of benefits to my provider at NBCC for any/all services rendered by my provider.

I am aware that State and Federal laws require NBCC to collect copayments, coinsurance and deductibles in full. I am responsible for paying my copayments, coinsurance, and deductibles at the time services are rendered. **I am aware that I am fully responsible for all fees not covered by my insurance company and that there is no guarantee that my insurance company will cover services.** NBCC will file with my insurance company and will bill me for coinsurance and deductibles that are due upon receiving an explanation of benefits. If my balance exceeds $200.00, after explanation of benefits from my insurance company, or if I am paying privately; my counselor may stop providing services until my balance is decreased to a reasonable amount. I will be contacted by my provider to address payment issues and possible referral to a lower fee service provider.

Fees

Initial Assessment		$200.00
Individual Session	45 min	$150.00
Individual Session	60 min	$180.00
Family/Marital Session		$180.00
Phone Session		$180.00 (prorated in 15 min increments)
Cancellation W/O 24 Hr Notice		$150.00 to $180.00
No Show		$150.00 to $180.00
Complete File Copy		$25.00 (1-20 pages/ $.50 per page thereafter)
Other Services Rendered		$180.00 per hr

Letters, Disability forms, or other forms completed by therapists (per occurrence): $30.00

Divorce/Child Custody Cases

The parent/guardian who accompanies the child to our center is responsible for payment. This includes co-pays, co-insurance, fee for service, and non participating insurance balances. ***Regardless of which parent carries the insurance on the child, we will collect from the parent that brings the child. We cannot get involved in custody specifics, e.g., one parent pays 80% and the other pays 20% towards medical expenses; as we are not a party to the court agreement. It is the parents' obligation to work out an arrangement themselves or through the court systems. In addition, a copy of the custody agreement must also be placed in each childs' chart before the initial session.***

Court Appearances

Jennifer Mitchell, PsyD is **NOT A FORENSIC PSYCHOLOGIST**, but if she is subpoenaed for court for any reasons fees are:

$500.00 per hr

Minimum retainer fee for legal services: $2000.00.

If you become involved in legal proceedings that require a therapist's participation, you will be expected to pay for the time, **even if the therapist is called to testify by another party.** Due to the difficulty of legal involvement, **a charge of $500.00 per hour** will be assessed for any preparation and attendance at any legal proceeding, including research of the client's previous therapy sessions. Professional fees for court appearances, depositions and attorney consultations including travel and waiting time, are non-refundable, are payable in advance only, and are not prorated as we have to block out time to be at court; thus preventing us from being able to see other clients during that time. **A minimum of $2000.00 is required and must be paid prior to any response to attorneys via telephone, provisions of clinical opinions, subpoenas, report preparation for either litigating party, or testimony.** The therapist at NBCC will not agree to court appearances or other legal involvement unless they have discussed the matter thoroughly and both therapist and the client agree to such involvement. The therapist will also decide whether involvement is within the range of therapist competence and whether or not court will interfere with the treatment relationship.I understand that if report preparation is required or requested, the rate for the preparation will be charged at the standard rate of a therapy session. Frequent and/or extended telephone, but the therapist is NOT subpoenaed for court, will also be charged for at the standard phone session rate. These services are NOT reimbursed by insurance.

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Your signature below means that you have read and understand the information contained in this form:
Signature: _____ Date: _____

Relationship to client: _____

I understand that this agreement is valid for the duration of time that I am participating in services with NBCC. By signing below, I acknowledge that I have received a copy of the **Informed Consent** and I understand and agree to the entire contents of these 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 participation in services. I am aware that I can stop therapy at any time. NBCC reserves the right to amend the **Informed Consent** at any time and copies will be available at the office of NBCC. I can request a copy of charges at any time at no charge. Any changes that NBCC makes are effective immediately unless otherwise indicated.

Signature: _____ Date: _____

Signature of Parent or Spouse (if applicable): _____

Patients are responsible for updating any and all insurance information with the front desk. If insurance denies a claim due to patients' not informing the front desk of new/updated information, the patient is held responsible for any and all charges assessed.

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PATIENTS' RIGHTS AND RESPONSIBILITIES

✔ I understand that Jennifer Mitchell, PsyD is a Licensed Clinical Psychologist in the State of Texas.

✔ I understand that Jennifer Mitchell, PsyD works with children, adolescents, and adults in individual 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 I am concerned about slow progress or lack of progress, I have the right to speak to my therapist at NBCC about this concern.

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

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

✔ I understand that Jennifer Mitchell, PsyD is not a psychiatrist and as such cannot recommend or prescribe medications, but can encourage clients to see an MD for a medical evaluation, and can provide consultation to MD.

✔ I understand that there are occasions when confidentiality can/must be breached. those occasions are: 1) the client request the therapist to tell someone else in writing or verbally; 2) the therapist determines that the client is a threat to themselves or others; 3) the therapist is ordered by court to disclose information; 4) the therapist suspects that child abuse has taken place, at which time he.she will notify Child Protective Services.

✔ I understand that the therapist and clients paths may cross in social situations, but the therapeutic relationship comes first, along with the protections of confidentiality.

✔ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to the therapist at NBCC.

✔ I understand that there is a $25 returned check fee and that if a returned check is not cleared within 30 days of receipt, NBCC will file suit with the Comal County District Attorney's Office.

✔ I understand that if I have a complaint I cannot resolve with the therapist at NBCC and I wish to file a formal complaint, I may contact the Texas Behavioral Health Executive Council online at bhec.texas.gov or call (800)821-3205.

✔ Emergencies: I understand that although NBCC does not provide formal emergency services, we try to be available to every extent possible. I may call the office number 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 be returned the next business day. If I find myself in an urgent situation, I have the choice of waiting for the return call, calling 911, or going to the nearest emergency room for immediate care.

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

Signature: _____ Date:_____

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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 standard rate, and this will not be covered by your insurance. If the office does not hear from you before your missed appointment, your credit card will be charged. If you need to cancel or are going to be late, please call the office at (830)625-0599. If you arrive late, the session will still end at the scheduled time. If you are going to be late and you still have not appeared within 15 minutes of your scheduled time, it will be considered a missed appointment and will be charged accordingly.

Credit Card Authorization Form

I, _____, hereby authorize NBCC to bill my credit card as listed below for professional fees for myself or _____.

I agree that NBCC may bill my credit card at the full fee of $_____ for professional services including the following:

(Please initial)
_____ Appointments that elect to pay by credit card.
_____ Missed appointments. (Standard rate)
_____ Appointments that have been cancelled less that 24 hours notice (Standard rate)
_____ Telephone consultations (billed in 15 minute increments based on $130.00 per hour)
_____ Balances of charges not paid by me or my insurance
_____ Insufficient funds/returned check fees.

Type of Credit Card:

___ Visa ___ Mastercard ____ Discover ___ American Express
_____ FSA cards (not for missed or cancelled appointments)

Name as it appears on card: _____

Card Number: _____

Expiration: _____

CVV/CID Code: _____

Zip for billing address: _____

Signature: _____

Date: _____

Charges will appear on your statement as New Braunfels Counseling Center.