New Braunfels Counseling Center
790 Generations Dr Ste 410
New Braunfels, TX 78130-6720
Phone: (830)625-0599
Fax: (830)625-5877

Darla Lane, LCSW-S
Angela McCree LMFT-A
Shar MCKelvie,LPC,LCDC.
Susan Greco, LPC
Randall Chavez, LPC
Melanie Blank, LCSW
Kelvin McCoy, LCSW, LCDC
Tifarah Canion, LPC-A
Mike Allen, LPC-A
Ulysees Cantero, LPC, LPL, AMFT
Ivonne Mouser, LPC
Stephanie Donnell, LPC

Date:_____

CLIENT CONTACT FORM

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

Gender: Male/ Female/Other Prefered pronoun: _____ Marital Status: M S D

Social Security:_____

Address: _____

City, State, Zip:_____

Cell Phone: (____)_____ Cell Phone Carrier: _____

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: _____

Email for parent/spouse/guardian:_____

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 why you are seeking services:

_____

_____

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Insurance Information

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

Client Name_____

Insurance Company_____

Insurance ID _____ Group number _____

Policy Holder Full Name: _____ DOB: _____ Sex: _____

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

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 I don't know** *(if yes a copy of the card is required and ask office staff for an additional form for insurance)*

Therapy Charges

Initial Evaluations	60 min	$225.00
Individual Sessions	60 min	$180.00
	45 min	$160.00 (individual)
Initial Family/Couples Evaluation	60 min	$225.00
Family/Couples/Group Therapy	45/60 min	$190.00 (family)

*** LPC-A's Intake/Sessions $175.00 /$150.00 and $175.00 for couples Intake/Sessions.*

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 canceled with less than 24 hours notice will be billed to me at the standard rate. If more than two therapy sessions are NO SHOW's and/or Late Cancellations in a two month period of time, 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 at any time. A $50.00 fee may be associated with the copy of records.*

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

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 (HIPAA): **(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 counselor 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 therapy 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 provider will review your message before your scheduled therapy session. The rate per hour for phone support is determined by session, prorated in 15 minute increments. If an emergency arises, please contact 911 or go to the nearest emergency room.

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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 clients 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.

I am aware that there is a **returned check fee of $35** 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 that 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 provider 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		$225.00
LPC-A sessions		$175.00/$150.00
LPC-A Family/Marriage		$175.00/$175.00
Individual Session	45 min	$160.00
Individual Session	60 min	$180.00
Family/Marital Session		$190.00
Phone Session		Rate: Determined per scheduled session
Cancellation W/O 24 Hr Notice		Rate: Determined per scheduled session
No Show		Rate: Determined per scheduled session
Complete File Copy		$50.00 (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): $50.00

Divorce/Child Custody Cases/CPS 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 DO NOT ACCEPT ANY ONGOING OR OPEN CPS CASES. If we discover an open CPS case we will immediately terminate services. 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.**

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Court Appearances

We are **NOT FORENSIC THERAPISTS**, but if we are subpoenaed for court for any reasons fees are:
$500.00 per hr

Minimum retainer fee for legal services: $2,000.00.
If you become involved in legal proceedings that require a provider's participation, you will be expected to pay for the time, **even if the provider is called to testify by another party.** Due to the difficulty of legal involvement, **a charge of $400.00 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 your provider from being able to see other clients during that time.*** **A minimum of $2,000.00 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 providers at NBCC **will not** agree to court appearances or other legal involvement unless they have discussed the matter thoroughly and both provider and the client agree to such involvement. The provider will also decide whether involvement is within the range of provider's competence and whether or not the 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 will also be charged for at the standard phone session rate. These services are not reimbursed by insurance.

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 read 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 counseling 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 changes at any time, at no charge. Any changes that NBCC makes are effective immediately unless otherwise indicated.

Signature of patient: _____ Date: _____

Signature of Parent (if patient is a minor): _____

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 and unpaid by the insurance company.

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PATIENTS' RIGHTS AND RESPONSIBILITIES

✓ I understand that I will see a Licensed Clinical Social Worker/ Licensed Professional Counselor/ Licensed Professional Counselor- Associate/Licensed Chemical Dependency Counselor/Licensed Marriage and Family Therapist in the State of Texas. (please circle the correct License).

✓ I understand that NBCC works with children, adolescents, and adults in individual, family/marriage counseling.

✓ I understand that as my provider, or the provider working on 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 provider 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 any LPC-A/LPC/LCSW/LMFT/LCDC at NBCC, are not psychiatrists and as such cannot recommend or prescribe medications, but can encourage clients to see an MD for a medical evaluation.

✓ I understand that my provider at NBCC does not perform formal testing; however I may be referred to a psychologist who can perform formal testing.

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

✓ I understand the providers 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 therapists at NBCC.

✓ I understand that there is a $35 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 provider 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, my provider will 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, the call will be returned before the end of the business day, in most circumstances. If the call is received overnight or on the weekends, it will be returned within 48 hours of receipt. 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:**_____

02/19/24 revised

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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 **$150.00** and this will not be covered by your insurance. If the office does not hear from you before your missed/no show 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 fees assessed for professional services including the following:

(Please initial)
_____ Appointments that elect to pay by credit card.
_____ Missed appointments. (Standard rate)
_____ Appointments that have been canceled less than 24 hours notice (Standard rate)
_____ Telephone consultations (billed in 15 minute increments based on $150.00 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 canceled appointments)

Name as it appears on card: _____

Card Number: _____

Expiration: _____

CVV/CID Code: _____

Zip: _____

Signature: _____

Date: _____

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

02/19/24 revised

New Braunfels Counseling Center

790 Generations Dr Ste 410, New Braunfels, TX 78130

INFORMED CONSENT CHECKLIST FOR TELE PSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

* There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
* Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
* We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist/ therapist will explain how to use it.
* You need to use a webcam or smartphone during the session.
* It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
* It is important to use a secure internet connection rather than public/free *Wi*-Fi.
* Certain platforms may not be secure and HIPPA compliant, if requested by the patient to use.. (e.g. Zoom, Facetime, FB Messenger)
* It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
* We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
* We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
* If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
* You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
* As your psychologist/therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist / Therapists Name / Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

Behavior Rating Scale

Name: _____ Date: _____

Age: _____ Name of Person Completing Form: _____

Relationship to person being rated: _____

Please circle the number below which best describes the frequency/severity of the problem:
1= Not at all; 2= A little, 3= Moderately/sometimes; 4= Often/quite a bit; 5= Extremely/always

Depression/Anxiety

1 2 3 4 5 Feeling down or blue; irritable; crying easily; feelings easily hurt; quick mood changes
1 2 3 4 5 Feeling hopeless about the future; thoughts of hurting self, thoughts about death or dying
1 2 3 4 5 Low self- esteem; shyness or problems making friends; sensitivity to criticism or rejection; feeling of inadequacy
1 2 3 4 5 Worrying about things too much; feelings tense, anxious, nervous, or shaky; phobias
1 2 3 4 5 Separation anxiety; clinging to and/or sleeping with parents; fearful of being away from parents; difficulty going to school or work
1 2 3 4 5 Nightmares; easily startled; avoidance; flashbacks related to past abuse or other traumas

Anger/Irritability/Behavioral Problems

1 2 3 4 5 Anger control problems; thoughts about hurting others; violence; fighting; temper tantrums; cruelty to animals; stealing; fire setting
1 2 3 4 5 Stubborn; defiant; trouble with authority; gang involvement; cult involvement

Relationships

1 2 3 4 5 Relationship problems; distrust; interpersonal isolation; frequent arguments
1 2 3 4 5 Problems with parenting, disciplining, and/or communicating with your child
1 2 3 4 5 Marital problems; family conflict; sibling fighting; conflicts with co-workers
1 2 3 4 5 Abusive relationships; victim abuse; perpetrator of abuse

Addictions/Compulsions

1 2 3 4 5 Alcohol or drug abuse; describe _____
1 2 3 4 5 Obsessive- compulsive behaviors (i.e. cleaning, working, exercise, rituals, gambling, counting); odd thoughts that you can't get out of your head; perfectionism; excessive need for control
1 2 3 4 5 Fatigue; low energy; problems concentrating

Sleep/ Eating/ Developmental/ Physical

1 2 3 4 5 Sleep disturbance (trouble falling asleep, restless sleep, waking too early and being unable to fall back asleep, sleeping too much)
1 2 3 4 5 Problems with eating/appetite (change in appetite/weight, bingeing/purging)
1 2 3 4 5 Bed wetting; soiling self
1 2 3 4 5 Developmental delays in speech/language; toilet training; motor skills; social/emotional functioning; cognitive/ academic skills
1 2 3 4 5 Aches and pains; lots of physical symptoms (without a known physical cause)
1 2 3 4 5 Sexual Problems

Academic/ Leaning/ Vocational

1 2 3 4 5 Learning problems; problems with memory; slowed thinking
1 2 3 4 5 Failing grades in school; declining work performance

Thought Process

1 2 3 4 5 Hearing voices or seeing visions; mental confusion; odd beliefs; paranoia

Stress

1 2 3 4 5 Stress management problems; difficulties coping and/or relaxing
1 2 3 4 5 Financial problems
1 2 3 4 5 Work related stress
1 2 3 4 5 Family problems (check all that apply below)
_____ Children difficult to manage
_____ Marital status
_____ Spouse abuse
_____ Child abuse
1 2 3 4 5 Legal problems; pending court case or lawsuit

Inattention/Hyperactivity

1 2 3 4 5 Hyperactivity; impulsive; restless
1 2 3 4 5 Inattentive; disorganized; forgetful; easily distracted

Other problems/concerns: _____