DALLAS FAMILY COUNSELING CENTER
New Client Information

Information Pertaining to Client

Client Last Name______________________First Name_____________________ M.I.__
Client Address____
City__________________________State_____________Zip Code_______________
Home Telephone (____)_________________ → Acceptable to leave message? Yes No
Cellular Phone (____)_________________ → Acceptable to leave message? Yes No
Birthdate of Client______________E-Mail Address_________________________
Social Security Number of Client_________________________Sex: M F (Circle One)
Employer Name & Address____
Responsible Party Phone (____)______________ Responsible Party Birthdate __________
Billing Address____
City__________________________State_____________Zip Code_______________
Marital Status: (Circle One)
M- Married S- Single Se- Separated D- Divorced W- Widowed
Who Referred You?____
Emergency Contact: _________________________ Phone: (____)_______________

Information Pertaining to Client's: ☐ **Spouse** ☐ **Parent** ☐ **Partner** ☐ **Guardian**

Last Name___________________________First Name___________________________
Address____
City__________________________State_____________Zip Code_______________
Home Telephone (____)________________Work Telephone (____)________________
Relationship to Client__________________E-Mail Address___________________
Birthdate________________Social Security Number___________________________
Employer and Address____

Insured's Insurance Information:
Relationship to Client: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Guardian** ☐ **Other______**

Insurance Co. Name______________________Phone Number (____)_______________
Insured Party Full Name______________________Relationship to Patient___________
Insured Birthdate _____________ Insured ID No. ____________________________
Group Name____________________Group ID No._______________________________
Employer______________________________ Authorization No. _____________

1. I hereby authorize the therapist whose name appears on my insurance claim form to furnish my insurance company with any requested information concerning my present treatment.
2. I hereby assign to the therapist whose name appears on my insurance claim for all monies to which I am entitled for psychological expense relative to the services reported on my insurance claim form. I understand that I am financially responsible to said therapist(s) for charges not covered by this assignment.

____
Insured/Guardian/Responsible Party Client Date

DALLAS FAMILY COUNSELING CENTER
Client Information and Office Policy Statement
Informed Consent

I. New Client: Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s).

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

III. Appointments:

Appointments are usually scheduled for 50 minutes. The practice's hours are 8AM – 9PM, Monday – Friday and 8AM – 5PM, Saturday. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, the on-call therapist may be reached at (770) 445-6358. This number will automatically roll over to the on-call therapist's pager if there is no one in the office. If you are unable to reach the on-call therapist, you may call your primary care physician, your local emergency room, or a crisis hotline.

IV. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1.) Suspected abuse or neglect of a child, elderly person or a disabled person, 2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) If you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4.) If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) In natural disasters whereby protected records may become exposed or 7.) When otherwise required by law. You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members. Please Review attached confidentiality policy for details.

Client Information and Office Policy Statement – continued

V. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your

written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site.

VI. Fees:

Fee for the initial visit is $ 175.00 -Ph.D & $150.00-LMFT, LPC .
Each 45-50 minute session thereafter is $ 150.00-Ph.D & $125.00-LMFT, LPC .

VII. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will give you a superbill or file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

VIII. CANCELLATIONS and MISSED APPOINTMENTS:

Failure to provide twenty-four (24) hours notice of cancellation for any reason will result in a charge of $55.00 – not just a co-payment. You may leave messages 24 hours per day. Insurance companies generally do not reimburse for failed appointments. After two (2) consecutive cancellations or missed appointments your therapist may refer you to another therapist.

Please Initial Here __________

IX. Returned Check Fee:

There will be $20.00 fee for any checks returned from your bank.

X. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

XI. Termination of Services

If at any point you choose not to continue therapy please notify therapist of decision immediately so that chart can be closed. If you fail to reschedule an appointment within eight weeks of your last session, therapy will officially be ended and you case will be deemed closed.

XII. Consent for Treatment

By signing below, you are stating that you have read and understood this 2-page Informed Consent Policy Statement and the attached Confidentiality Policy, and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

____
Name of Patient (please print)

____
Name of Responsible Party (if different than Patient)

____
Signature of Patient Date

____
Signature of Responsible Party Date

____
Signature of Therapist or Witness Date

DALLAS FAMILY COUNSELING CENTER

To reserve a one-hour time slot with your assigned therapist we are requiring all patients to agree with the following policy.

Late Cancellation / No Show Policy

Failure to provide twenty-four (24) hours notice of cancellation for any reason will result in a charge of **$55.00** – not just a co-payment. You may leave messages 24 hours per day. Insurance companies generally do not reimburse for failed appointments. After two (2) consecutive cancellations or missed appointments your therapist may refer you to another therapist.

I have been made aware and agree to comply with this policy and have been given opportunity to ask questions.

Signature of Patient	Date	Signature of Responsible Party	Date

Dallas Family Counseling Center

FEE SCHEDULE

Procedure	Cost
1. Initial Assessment (45-50 min)	
--Psychotherapist	$150.00
--Psychologist	175.00
2. Individual/Couples/Family Therapy (45-50 min)	
--Psychotherapist	$125.00
--Psychologist	150.00
3. Alcohol & Drug Evaluation (Typed Report)	$225.00
4. Anger Assessment (Typed Report)	$225.00
5. Psychological Assessment - MMPI (Typed Report)	$325.00
6. Psychological Testing & Evaluation	$750.00
7. Telephone Consult – Not covered by Insurance	
--(20-30 min)	$50.00
--(15-20 min)	25.00
8. Failure to Provide 24 hours Notice of Cancellation	$55.00
9. Medical Records	$0.93/page
10. Court On-Call Appearance Fee	
--Four (4) Hour Block	$600.00
* Fifty Percent (50%) Deposit Required One (1) Week Prior To Court Date *	
11. Assessment Scoring Fee	$15.00
12. Fill out Forms, Letters, Etc.	
--Per ¼ Hour ($25 minimum)	$25.00

If you use your insurance, the co-pay is required at time of service. If your insurance has a deductible, full session fees will be required until the deductible is met. If for some reason your insurance does not cover services, you will be responsible for full session fees. If you have any further questions please feel free to ask.

I HAVE READ, UNDERSTOOD, AND AGREE TO THESE FEES & POLICIES

Signature ______________________________ Date ____________

DALLAS FAMILY COUNSELING CENTER

Patient's Rights and Responsibilities Statement

Statement of Patients Rights

Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Their treatment and other member information be kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about their insurance company, its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the patient's rights and responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patients Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know if the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, I have read the HIPPA guidelines presented to me at sign-in, and that I understand this information.

____

Member Signature Date

The signature below shows that I have explained this statement to the patient, and have offered them a copy of this form and the HIPPA form.

____

Provider Signature Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

WHCF-10-ENV / WHCF-10-ENV-SS

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. ___ . ___

2. ___ . ___

3. ___ . ___

4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS