Suzanne L. Balka, MS, LPC
Professional Counseling & Psychotherapy

New Client Intake Forms

Date:_____

Client Name:_____
Address:_____City:_____State:_____Zip:_____
Phone:_____Work Phone:_____Cell Phone:_____
Date of Birth:_____Social Security #:_____
Check Appropriate Box: □ Minor □ Single □ Married □ Widowed □ Separated □ Divorced
If Student, Name of School:_____City/State:_____□ FT □ PT
Spouse of Parent's Name:_____Employer:_____
Work Phone:_____
Whom may I thank for referring you?:_____
Person to Contact in case of emergency:_____
Phone:_____
Email Address:_____

Responsible Party Name:_____
Relationship to Patient: □ Self □ Spouse □ Parent □ Other
Address:_____
City:_____State:_____Zip:_____
Phone:_____
Employer:_____Work Phone:_____
SSN#:_____

Name of Insured:_____DOB:_____
Relationship to Client:_____
SSN#:_____Name of Employer:_____
Work Phone:_____
Address of
Employer:_____City:_____State:_____Zip:_____
Insurance Company:_____Group#:_____
ID#:_____
Ins Co Address:_____
Ins Co. Phone:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ Yes □ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured:_____DOB:_____
Relationship to Patient:_____SSN#:_____
Name of Employer:_____Work Phone:_____
Address of Employer:_____City:_____State:_____Zip:_____
Insurance Company:_____Group#:_____ID#:_____
Insurance Co. Address:_____
Insurance Co. Phone:_____

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New Client Intake Forms

Client-Therapist Service Agreement

Welcome! This document contains important information about my professional services and business policies. It also contains summary information about the **Health Insurance Portability and Accountability Act (HIPPA)**, a federal law that provides privacy protections and patient rights about the use and disclosure of your **Protected Health Information (PHI)** for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future. Psychotherapy is a relationship between client and therapist that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Psychotherapy

There can be many goals for the psychotherapy relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness, increasing consciousness, reaching self-actualization goals and working on personal development. Others may be more immediate goals such as decreasing anxiety and depression symptoms, improving self-esteem, developing healthy relationships, changing certain behaviors or decreasing/ending bad habits that are negatively impacting one's life. Whatever the goals for therapy, they will be set by the client according to what they want to work on during treatment. The therapist may make suggestions on how to reach that goal but you decide where you want to go.

Risks/ Benefits of Therapy

Psychotherapy is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling/psychotherapy will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to therapy. It can help you develop coping skills, change chronic negative thought patterns, make behavioral changes, reduce symptoms, improve the quality of your life, learn to manage anger, improve self-esteem, learn to live in the present moment and many other advantages.

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Appointments

Appointments will ordinarily be between 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. Please remember that a canceled appointment delays our work. When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a canceled session unless I know at least 24 hours in advance. It is important to note that insurance companies do not provide reimbursement for canceled sessions. ***If you are unable to provide at least 24 hours notice when you cancel, you will be charged the full fee for your session unless I am able to fill it with another client. The only time I will waive this fee is in the event of serious or contagious illness or emergency.*** In addition, you are responsible for coming to your session on time, if you are late, your appointment will still need to end on time.

Confidentiality

As your therapist, I will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limits to confidentiality to which you need to be aware. Sometimes professional consultation with a state licensed supervisor or other professional counselor is in order to give you the best psychological services. In the event of any consultation with another counselor, no identifying information such as your name would be released. Therapists are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If I receive a court order or subpoena on behalf of a client, I may be required to release some information. In such a case, I will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Technology

Some clients may choose to use technology to manage their therapy appointments, or communicate with the therapist about their treatment. This includes but is not limited to phone, email and/or text communications. Due to the nature of said communications, there is always the potential that unauthorized persons may attempt to discover your personal information. I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used during your course in psychotherapy treatment with me. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology where communications about treatment were discussed and/or personal information about your therapy appointments could be found. Please discuss with me any concerns you may have about the safety of any and all electronic communications while in treatment.

Record Keeping

As your therapist, I will be keeping records of your therapy sessions and a treatment plan which includes goals for your treatment. These records are kept to ensure a direction to your sessions and continuity in

service. They will not be shared except with respect to the limits of confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically, or in a paper file and stored in a locked cabinet in the therapist's office following standard HIPPA policy and procedure. As your therapist, I make every effort to have a paperless office, and prefer storing information whenever possible electronically. However, during your course in treatment there most likely will be some writing exercises in session and the therapist prefers to keep this information in a paper file so that it can be easily retrieved in subsequent sessions for reference and reinforcement.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit card, check or cash.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

Fees are generally non-negotiable; however a sliding scale may be available on a limited basis.
Fees for services are listed below. Fees are subject to change at the therapist's discretion.

90791 Psychiatric diagnostic evaluation (intake) - $120

90837- Psychotherapy 50- 60 minutes- $100

90847- Couples/ family Psychotherapy 50-60 minutes- $115

Copies of files, letter writing, or other reports produced: $20 Administrative fee

Returned check fee- $35

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental/behavioral health services. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this agreement, you agree that I can provide requested information to your carrier if you plan to utilize your insurance benefits.

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In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover services. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee or co-payment to be covered by the patient. Either amount is to be paid at the time of the visit. In addition, some insurance policies also have a deductible, which is an out-of pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. It is important to know what your policy specifically entails.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for possible partial reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times when I am not available, you may leave a message on my confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is a crisis/emergency situation, please either contact the local crisis hotline @713-468-5463, go to your local hospital, or call 911. Please understand that if you are calling over the weekend, your call will be returned on the next business day. Please make note that I am not equipped to offer after-hours crisis care.

Email/Text Appointment Reminders

As your therapist, I would like to request your email address and cell phone number for the purpose of sending appointment reminders via text or to periodically check in with clients via email, who have ended therapy suddenly and/or to send valuable therapeutic information that would be helpful to their treatment. Please indicate your cell phone number for receiving text appointment reminders:

Phone:_____

Email address for follow-ups and receiving other valuable information:

Email:_____

Discontinuation of Services

If for any reason you would like to discontinue your therapy, I will explore alternative choices with you and make appropriate recommendations during a closing session. I can then assist to develop a transition plan for the client, based on clinical needs. In the event that I feel therapy is not moving toward established goals: when it is clear the client is no longer benefiting, when services are no longer

meeting the needs of the client, or the client is not willing to pay the agreed upon fee for services, therapy can be terminated and clinical referrals will be made through appointment or letter. The client has the right to terminate therapy at any time for any reason. Closure is an important part of the therapeutic relationship for both the provider and the client. For this reason I encourage a termination session for all clients that are ending clinical services with me.

I have read and understand the above guidelines of the Client-Therapist Service Agreement. I have been given the opportunity to ask questions and have been informed of the rights of confidentiality and my rights as a client. I understand that portions of this contract (such as email/texting) can be renegotiated at any time by my request or consent. I agree to the treatment, procedures, and goals of therapy as discussed with the provider. At my request I may receive a copy of the informed consent and the treatment plan.

Your signature below indicates that you have read this agreement and agree to its terms.

Client name: _____

Client signature (or Parent/Guardian signature if client is a minor):

_____ Date:_____

Licensing Information:

Suzanne L. Balka, MS, LPC is a Licensed Professional Counselor #68504 registered with The Texas State Board of Examiners of Professional Counselors whom may be contacted at (800) 942-5540.

New Client Intake Forms

Authorization For Use Or Disclosure Of Protected Health Information (PHI)

CLIENT'S NAME:_____
FIRST NAME MIDDLE NAME LAST NAME

DATE OF BIRTH:_____
DATE OF AUTHORIZATION:_____
AUTHORIZATION INITIATED BY:_____
NAME
INFORMATION TO BE RELEASED:_____
PURPOSE OF DISCLOSURE:_____
PERSON AUTHORIZED TO MAKE THIS DISCLOSURE:_____
PERSON AUTHORIZED TO RECEIVE THIS DISCLOSURE:_____

_____
ADDRESS PHONE

- This authorization will expire 1 year from_____or upon verbal instruction.

AUTHORIZATION AND SIGNATURE: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

SIGNATURE OF CLIENT:_____

SIGNATURE OF PERSONAL REPRESENTATIVE:_____

REPRESENTATIVE'S RELATIONSHIP TO CLIENT:_____

DATE OF SIGNATURE:_____

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Insurance Authorization Form

- ✓ Balance of charges not paid by insurance or patient within 90 days.

1. I the undersigned accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made with your therapist.
2. Authorization for release of information: I hereby authorize the release of information regarding me/minor's condition or treatment to insurance company.
3. Authorization to pay insurance benefits to the provider: I hereby authorize the payment of increased benefits from my insurance company to my provider.

I understand that this form will remain valid indefinitely unless I cancel authorization through written notice to the service provider.

Patient's Name:_____DOB:_____

Patient (or responsible party) Signature:_____

Date of Signature:_____

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New Client Intake Forms

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict my private information that is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

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