INDIVIDUAL FORM

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_ SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Primary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please indicate: Cell/Home/Work/Other\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please indicate: Cell/Home/Work/Other\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we contact you at this number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. referral information, change of appointment times****).***

**I do give HILL COUNTRY PSYCHOTHERAPY staff permission to leave telephone messages and/or send faxes regarding my care to the following phone numbers:** Cell #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Initials \_\_\_\_\_\_\_\_\_

Cell #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Initials \_\_\_\_\_ Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials \_\_\_\_\_\_\_\_

Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials \_\_\_\_\_ Fax Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials \_\_\_\_\_\_\_\_

*Please initial each phone number that you want us to be able to use for leaving you telephone messages or faxes. You may revoke permission at any time in writing.*

|  |  |  |
| --- | --- | --- |
| Please list the names of all individuals you have been married to, with the most recent first. If never married, please leave blank. | For how many years  | Are you currently married? Yes or No |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please list Children:If no children list siblings | Age | Sex | Birthdate | SSN | Do they live at home with you? Yes or no |
|  |  |  |  |  |   |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Are your parents living? Mother Yes\_\_\_\_\_ No\_\_\_\_ Father Yes \_\_\_\_\_ No\_\_\_\_\_

Are there any other persons living in your household? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please provide their name(s), ages, and their relationship to your family.

Please give the name, address, and telephone of the nearest relative/friend in case of an emergency. Emergency contact may be called if suicidal or homicidal ideation is present.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BASIC HEALTH AND COUNSELING HISTORY

Good\_\_\_\_ Fair\_\_\_\_ Poor\_\_\_\_ Date of last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of General Physician or Internist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Psychiatrist (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had counseling in the past? Yes\_\_\_\_\_ No\_\_\_\_\_ If so, From (date): \_\_\_\_\_\_\_\_\_\_ To (date):\_\_\_\_\_\_\_\_\_\_

Counselor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what reason(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all of your physical and medical health issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications (prescription, over-the-counter, allergy, herbal, etc.)? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please list all medications and current dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for physical reasons? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

 If so, for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of hospitalization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for mental health reasons? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

 If so, for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of hospitalization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes\_\_\_\_ No\_\_\_\_ If yes, amount and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use any illegal/illicit drugs? Yes\_\_\_\_ No\_\_\_\_ If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any disabilities that we need to accommodate? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe any accommodations that we can make to assist you. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RATE YOUR CURRENT MENTAL STATUS by circling G, F or P for each item listed below:

 **G = Good F = Fair P = Poor Comments**

Memory/Short G F P

Memory/Long G F P

Insight/Judgment G F P

Attention G F P

Concentration G F P

Affect/Mood G F P

Eye Contact G F P

Body Movement G F P

Speech G F P

Impulse Control G F P

CURRENT REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

What would you like to see happen as a result of counseling?

**HILL COUNTRY PSYCHOTHERAPY ASSOCIATES**

**INFORMED CONSENT**

**The Therapeutic Process**

A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with interpersonal relationships. Another possible benefit may be a greater understanding of personal goals and values; this may lead to greater maturing and happiness as an individual. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits, however, therapy will require that firm efforts be made to change and may involve the experiencing of emotional discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, and frustration. Seeking to resolve issues between family members, partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended. It is helpful to discuss with your therapist any questions or discomfort you may experience during the therapeutic process.

Your counseling session will usually be either 45 or 60 minutes. Depending upon the nature of the presenting problems, the frequency and length sessions is difficult to initially predict. Your counselor will get to know you the initial sessions to create a treatment plan, and after the first few sessions he or she will better be able to discuss the probable time frame for sessions and your therapist will better be able to discuss the probable timeframe for the counseling process. Depending on the issues you bring to counseling, as well as your goals, your therapist will create a treatment plan that utilizes a variety of techniques including, but not limited to: Cognitive Behavioral, Psychodynamic, Experiential, Solution Focused, and Systemic techniques.

**Your Privacy**

Under most circumstances, all of your information about you will be kept confidential. However there are several exceptions to confidentiality mandated by state law and professional regulations. Information will not be disclosed to any outside person or agency without your written permission except in specific situations, which include:

* You are determined by your therapist to be in imminent danger of harming yourself or someone else
* If you disclose abuse or neglect of a child, elderly or a disabled person
* If you disclose sexual misconduct by a mental health professional
* To qualified personnel for certain types of audits or evaluations
* In the case of a legitimate subpoena issued by a judge
* In legal or regulatory actions against a professional
* In the case of children, please be aware that both parents may have the right to the child’s records.
* If applicable, I have signed the release of information form for my insurance company or EAP program and I have been given the information form detailing the privacy and confidentiality as required by the Health Insurance and Portability and Accountability Act (HIPPA) of 1996.
* I understand and give permission to my therapist to consult about my situation when necessary.

**Fees and Arrangements for Payment**

 My standard fee is $130 for the initial session and then $110 for each subsequent session. Some companies may cover part of this cost. If you have coverage, you are welcome to assign your benefits and pay only your copay. If your policy has a deductible that has not been met you are responsible for paying the rate negotiated by your insurance company until your deductible has been met. We are not allowed to waive copayments or deductibles.

 Your health insurance company will only pay for services that it determines to be reasonable and necessary. If your insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under your plan, your insurer will deny payment for that service. If my insurance company denies payment, your will be personally responsible for payment.

It is customary to pay your therapist each session. Hill Country Psychotherapy Associates requests that you pay your copay prior to your session to increase efficiency. If this is an issue for you we will collect your copay after your session. We accept cash, check, Mastercard or Visa. We do not provide reminder appointments after the first session. Please record your appointment time as you will be responsible for any fees incurred from no shows or late cancellations. We require a 24 hour notice for cancelling or rescheduling appointments. Your insurance company will not pay for any missed or cancelled appointments. ***If you fail to cancel your appointment with at least 24 hour advance notice, you will be charged for the full fee for your session, not just your copay.*** Please refer to our financial policy for additional information.

I consent to treatment and understand the above information. I understand I have the right to refuse treatment at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CLIENT OR PARENT SIGNATURE CLIENT OR PARENT PRINTED NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PARTNER SIGNATURE IS COUPLES PARTNER PRINTED NAME IF COUPLE DATE

**FMLA/DISABILITY PROCEDURES**

 At HCPA, our private practice functions to aid clients with issues they are facing in their lives through the counseling process, and our therapists do not focus on attaining FMLA/disability for clients, although it may be appropriate in certain cases. **Counselors do not fill out FMLA/disability paperwork on your first counseling session.**  **If your counselor agrees to complete FMLA or disability paperwork it will take a minimum of three and five sessions for him or her to assess the detailed information your disability company is requesting. Bringing in paperwork does NOT automatically qualify you for paid leave from your employment.** Please talk to your therapist at the first session if you have any questions regarding FMLA or disability paperwork.

 Your insurance company, employer or Social Security Administration, not your therapist, determines if you are eligible for FMLA or disability. All information completed by your therapist will be honest and professional. Any attempts to sway a clinician to modify professional, honest information will result in client termination and a referral to another therapist. You must meet the treatment requirements determined by your insurance company or employer to receive FMLA or disability payments.

 There is a **minimum $25.00 fee for each set of FMLA or disability paperwork**. **The first two pages will be charged $25.00. Each additional page filled out by your counselor will incur an additional $10 fee per page.** Each new request or set of paperwork will incur an additional fee and is required before completed paperwork will be given to you, faxed, emailed, or mailed. Any requested letters or additional documents require a minimum of five business days to complete and will incur an additional fee. Letters and paperwork requested to be completed in less than two business days will be assessed on a case-by-case basis and are not guaranteed. If the therapist agrees to complete the paperwork sooner than two businesses days there will be a minimum of a $50 rush fee.

HCPA clinician completing FMLA/disability paperwork will not always suffice. Many times, you will also have to have a Medical Doctor complete a set of FMLA/disability paperwork also. Your physician may charge fees as well.

I have read and understand and agree to comply with HCPA’s policy on FMLA/disability paperwork.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature or Parent Signature if Minor Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Signature if Couple Date

**CLIENT LITIGATION STATEMENT**

 Hill Country Psychotherapy Associates clinicians do not generally participate in any custody disputes or child custody, or any other litigation where the client, or parent/guardian, or other representative entity are parties. The clinician will make every effort to be uninvolved in any litigation or custody disputes between the client’s parents. The clinician will not voluntarily provide records, testimony, or any other information unless compelled to do so.

 If subpoenaed, the issuing part **agrees to pay $300 upfront, a nonrefundable fee for traveling, planning and court appearance, up to two initial hours, whether the clinician testifies or not. Each additional hour past the first two, will incur an additional fee of $150.00 per hour, charged the day of the court request to a Visa or MasterCard already on file, the same day, to cover additional expenses including document preparation, court summaries, depositions, and attorney consultations.** These fees will not be reimbursed by your insurance company.

 As indicated by my signature below, I hereby release, waive, discharge, and covenant not to sue the clinician as stated above, treating myself, my family, or a minor, in the event that he/she is compelled by a court of law or presiding judge to provide testimony or documentation that may result in an unfavorable ruling, order, motion, or modification thus holding him/her harmless and free of liability, damages, or costs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature or Parent Signature if Minor Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Signature if Couple Date

**HILL COUNTRY PSYCHOTHERAPY ASSOCIATES**

**FINANCIAL POLICY**

***HCPA strives to provide and maintain successful psychotherapist-client relationships. Please read our financial policy carefully to ensure good communication and understanding of our relationship. Please speak with us regarding any questions or concerns with our policy.***

* We call and verify your insurance benefits/authorizations before you are treated at our facility; however, it is your responsibility to understand your benefit plan, know if a preauthorization is needed, and what services are covered.
* You are responsible for all co-payments, coinsurances, and deductibles, which are required at the time of service. A **$10.00** processing fee will be applied if you do not make payment at the time of service or by the next business day.
* A quote of benefits and/or authorization from your insurance company does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the members’ contract at time of service. If your health insurance company determines that a particular services is not reasonable or necessary, or that a particular service is not covered under your insurance plan, your insurer will deny payment for that service. You will be personally responsible for session fees denied by your insurance plan.
* We file one, primary insurance only. If you have secondary insurance, we will provide you with a receipt so that you may submit to your secondary insurance company, which will send the reimbursement check directly to you. You will still be responsible for any co-payment, coinsurance, deductible, or balance on your account.
* If you do not have insurance, or your therapist is not contracted with your insurance plan, full private payment will be due at the time of service.
* **We require a 24 hour notice for cancellation or rescheduling. If a 24 hour notice is not given, then the full fee will be charged to you, not just your co-pay. Your insurance will not pay for any missed appointments, or appointments that are canceled or rescheduled. If you have an EAP, after two no shows/late cancellations, you will no longer be rescheduled. If your appointment is on a Monday, leave a message on the Sunday prior, at least 24 hours before your scheduled appointment time. Emergencies will be handled on a case by case basis and do not include work, school, childcare issues, or forgetting. If you cancel within 24 hours, your time slot may be filled by other clients, since we do not “overbook”. You are responsible for knowing when your next session is.**
* Reminder calls may be requested, but are not guaranteed. Our office does not email or text reminders.
* A **$40.00** fee will be charged for returned checks in addition to any bank fees incurred.
* A minimum of **$25.00** is charged for copies of medical records **OR** to fill out any disability paperwork. Each new set/update of disability paperwork incurs a new minimum **$25.00** charge.
* Any outstanding account balances past due **30 days** will incur a **$15.00** rebilling fee. Any outstanding balances past due **60 days** will be forwarded to a collection agency and a **35%** fee will be added to your total account balance.

**I have read and understand HCPA’s financial policy. I agree to keep HCPA informed of my current mailing address and phone numbers, as I will be notified of balances due by mail only. I agree that if it becomes necessary to forward my account to a collection agency that I will also be responsible for any processing fees in addition to the original amount**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature or Parent Signature if Minor Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Signature if Couple Date

**Release of Information to Your Managed Care Company**

You have chosen to utilize some form of your mental health insurance benefits and/or EAP. According to your insurance carrier, state and federal laws, we must have your consent to release information to your EAP or managed care company in order for your clinician to request and be granted approval for your sessions when required, and to bill your insurance company for your psychotherapy sessions. Your insurance company will not cover the charges at an in-network rate if preauthorization is not requested, when required, in most cases.

When pre authorization is required for initial sessions, your managed care company will provide your clinician with an outpatient clinical review form. The managed care company will ask your clinician to provide them with information about your case. Once the managed care company has reviewed the information submitted, they will notify our office on the number of additional sessions approved. The information being released is considered instrumental to the ongoing evaluation and treatment of the patient. Your insurance company also requires clinical information in order to bill your psychotherapy sessions for payment.

In the event that the insurance company refuses payment, you are responsible for the unpaid balance. If you fail to pay within 60 days, or fail to make payment arrangements with your clinician, HCPA has the option of sending your bill to a collection agency. Should this occur, additional fees may apply. Please refer to our financial policy for details.

I do hereby authorize my clinician to discuss or release any information about my case to my managed care company which is deemed medically necessary for treatment or billing purposes. I understand I may revoke my consent at any time in writing. Should I revoke my consent, I understand this means my insurance company can no longer be billed for my treatment, making me responsible for the full private payment fee for any treatment I have received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature or Parent Signature if Minor Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Partner Signature if Couple of Family Therapy Date

**Hill Country Psychotherapy Associates, PLLC**

**4230 Gardendale, Bldg 601**

**San Antonio, TX 78229**

**210-558-0409**

**OPTIONAL CREDIT CARD PREAUTHORIZATION**

This form is not required. Many clients choose to fill this form out in order to authorize payment for a family member or for a Health Savings Credit Card. Please note that No Show and Late Cancellation fees cannot be charged to a HSA or FSA card due to federal guidelines.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Hill Country Psychotherapy Associates, PLLC** to keep my signature on file and to charge fees (including co pays, cancellation fees, records fees, etc.) to my credit card account for services rendered as of \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_.

CREDIT CARD: \_\_\_\_\_ VISA \_\_\_\_\_ MASTERCARD FSA/HSA YES NO

CARD NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CODE ON BACK OF CARD\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization is valid until canceled in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINTED NAME DATE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE DATE**