Counseling Institute of Irving
1300 Walnut Hill Lane
Suite 200
Irving, TX 75038
972-550-8369

STAFF:
Craig W. Spillman, Ph.D., L.P.C., L.M.F.T., N.C.C.
James H. Larson, M.A., L.P.C., N.C.C., N.B.C.C.H., C.A.R.T.

Interns

Welcome to the Counseling Institute of Irving.

The following information is to ensure your understanding of our policies and procedures. If you have any questions, please feel free to ask for clarification from your therapist.

1. By signing this document I give my permission to be treated by a therapist at the Counseling Institute of Irving. I understand that I am entering into a professional relationship with my therapist and that no other relationship will exist between therapist and patient.

   _____
   Initials

2. I have been informed that the Counseling Institute of Irving functions under the ethical code of the Texas State Board of Examiners of Professional Counselors and the ethical code of the Texas State Board of Examiners of Marriage and Family Therapists. The address and phone number for each licensing board is displayed in the waiting room. Complaints may be addressed to the Board listed on that form.

   _____
   Initials

3. I understand that all counseling sessions and records are confidential. All records are stored electronically for five years and then purged. No information can or will be released without written consent except in the cases of child abuse; elder abuse; potential suicide; potential homicide; and court ordered subpoena.

   _____
   Initials

4. I understand that using a managed care company significantly decreases confidentiality and that my therapist has no choice but to report summaries and, at times, complete details to a case worker at the insurance company.

   _____
   Initials

5. I understand that each session will last 45 minutes; that each session is scheduled in advance and that in the event that I do not cancel my scheduled appointment with 24-hours notice that I will be charged the regular fee for that session. I have been informed that the Counseling Institute of Irving has a 24-hour answering service that I may use at any time in the event of an emergency, or to cancel my appointment. EMAIL IS NOT SUFFICIENT FOR CANCELLATIONS WITHIN 24 HOURS of an appointment, please call the office.

   _____
   Initials

Counseling Institute of Irving
1300 Walnut Hill Lane
Suite 200
Irving, TX 75038
972-550-8369

[Please print]

Patient Name: _____ DOB: _____ SSN#: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Insurance ID #: _____ Insurance group #_____ Insurance Phone #: _____

****

Insured's Name: _____ Employer: _____

Home Phone: _____ Work Phone: _____ SSN#: _____

Home Address: _____ City: _____ Zip: _____

Our fee is $225.00 per 45 minute session. This fee applies to in office, phone or E-mail consultations. As with any professional service payment is expected in full at the time services are rendered unless specific arrangements have been made with your therapist indicating otherwise. If your insurance carrier covers outpatient mental health care and you wish to take advantage of your benefits, please complete the supplied insurance form. In the event your insurance company does not pay, you are responsible for paying the fee.

CANCELLATION POLICY

In the event that you must cancel a scheduled appointment you are expected to give at least 24 hours notice to this office. The 24 hour notice must occur on any business day, which includes Monday - Friday. Weekends and holidays are excluded. We have a 24-hour answering service for your convenience.

Failure to give 24-hours notice of a cancellation within the limits described will result in full payment expected for the missed session.

All invoices from this office to your insurance company or to you personally will be in the name of the office or Craig W. Spillman, Ph.D. All authorizations and precertifications are in the name of the practice or Craig W. Spillman, Ph.D. *Should you request authorization in any other name, you will be responsible for the cost of your treatment as your insurance company will authorize services only in the name of the practice which is Counseling Institute of Irving, or in the name of Craig W. Spillman, Ph.D.*

By my signature below, I am indicating that I understand and agree to the terms of this financial agreement, that I understand the ramifications of a cancellation without 24 hours notice and/or requesting authorizations in any name other than Craig W. Spillman, Ph.D.; Counseling Institute of Irving.

Signature: _____ Date: _____

6. Please note, you are fully responsible for paying for services in our office. Additionally, I have been informed that the Counseling Institute of Irving employs an outside collection agency and attorney for the purpose of collection of delinquent accounts. A minimal late fee of $25.00 will be charged if your account has to be sent to collection. _____ Initials
7. I have been informed that if my sessions are court ordered/mandatory, to be part of a lawsuit, a disability claim, divorce proceeding, child custody etc., that my therapist will not represent me in court or fill out any type of lawsuit paperwork or disability claims unless agreed to prior to our first session. There is a fee for any time spent filling out any agreed to forms.

_____ Initials

[Please print]

Emergency Contact Name: _____ Phone: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ Zip: _____ Phone: _____

Referred By: _____

Medications: _____

_____

HIPPA rules require written consent for any communication between our office and you or your designated friend/family member. Please list here the name and phone number of the person/s who you give consent for our office to contact. Additionally if you would like us to communicate with you via email, please sign below.

Person who we may contact on your behalf: _____

I give the Counseling Institute of Irving permission to communicate with me via email at the following email address: _____.

****

Many managed care companies require that we interact with the patients PCP to coordinate care. Do you give us consent to exchange information with the above named doctor?

Yes ____ No ____ Please sign for either response

Patients Signature: _____ **Date:** _____