Living Life Counseling & Associates - Demographic Information

Phone (512) 512-966-5405 Fax (512) 819-0256
3008 Dawn Drive Ste 101
Georgetown, Texas 78628
www.livinglifecounseling.org

Client Name: _____ DOB: _____

Primary Care Doctor: _____ Phone:_____
Specialist Doctor: _____ Phone: _____

Other Treatment Provider chiropractor, nutritionist, acupuncturist:
_____
Illnesses, Conditions, or previous Diagnosis Physical or Mental:
_____
Current Medications and Dosages:
_____
Previous mental health Medications:
_____
What prompted you to call for an appointment?
_____
_____
How were you referred: _____
Have you ever been hospitalized, Physical or Mental:
_____
_____

Any History of abuse? Please Circle Physical Emotional Sexual Emotional Neglect

Have you suffered a traumatic event? Ex. Car Crash, Hurricane, Deployed Military Service, Assault…
_____

Significant Losses in your life and year:
_____
_____
Do you feel like you have resolved these issues? How? _____
Any family history of mental illness? Please circle and indicate what relation: _____

Anxiety Depression Bipolar ADHD Schizophrenia Learning Difficulties

Any family history of substance abuse or addiction? If yes, what relation and substance:
_____
Are there any possible legal issues or court action which is related to you or could be related to your treatment? Yes No If Yes, Please explain:
_____
_____

Signature: _____ Date: _____

Living Life Counseling & Associates - Client Therapist Contract

The counseling relationship is a professional process intended to help you resolve personal challenges, adapt to life changes, or explore your current life situation. Some may enter counseling to identify goals and to develop a plan to achieve these goals, overcome or learn to live with a mental illness or disability, to change a behavior, or seek support. Your therapist will employ a variety of educational and therapeutic techniques, specifically affective (feeling) behavioral (doing) and cognitive (thinking) to help you achieve your personal counseling goals. These may include out of session counseling exercises or homework. Some clients can accomplish a great deal in a short period of time. Those with complex issues or histories will require more time. Just as people are unique so is their therapy program. Your therapist is an LPC/LPC Intern. If at any time during the therapeutic process you are dissatisfied with your therapist's services please let her or him know. If she or he is unable to resolve your concerns, you may report your complaint to the appropriate state board or supervisor. LPC's are licensed by the Texas State Board of Examiners of Professional Counselors. Each board may be contacted for complaints at 1-800-9425540.

Counseling is a very intimate process emotionally and psychologically. Your therapist's role is to help guide you through this process. Your relationship will be purely professional. Licensed Mental Health Practitioners are held to strict ethical guidelines and are prohibited from having any dual relationships with their clients. Your contact with your therapist will be limited to paid sessions only. Counselors at Living Life Counseling do not engage in social networking with clients. The therapeutic process has a very distinctive beginning, working stage, and a conclusion. Closure at the termination of therapy is important for you to have an opportunity to review and internalize what you have gained. In some cases termination of therapeutic services may be necessary prior to planned therapeutic termination. Examples of these cases are non-payment for services, threatening or abusive behavior toward the therapist, or consistently missed or cancelled appointments.

You will need to complete a social history (your personal story) prior to or during your first session. You and your therapist will begin by reviewing any further information that may be pertinent to you. If another professional (physician, minister, school personnel, or attorney) referred you or if any other information needs to be collected your therapist will ask you to sign a limited and specific release of information. You will then work on identifying your reasons for pursuing therapy and develop a realistic goal and plan.

If you are seeking services for a minor child or adolescent by signing this contract you are affirming that you, as the custodial parent or guardian, have the legal right to present the minor, sign any contracts as they may pertain to the minor, consent to release of information for the minor, and consent to the minor actively participating in counseling and in the therapeutic process. The therapist may require you to participate in family sessions in addition to the child's individual sessions. If parents are divorced your therapist will require you to provide them a copy of the divorce decree as it pertains to custody and parental rights to consent to psychological / psychiatric / mental health treatment. It is your responsibility to present the divorce decree or custody agreement in either print or digital format to the therapist. Failure to do so will result in termination of the therapeutic relationship. Any omission of information regarding imminent, or ongoing custody or legal conflict may result in termination of the therapeutic relationship.

All of your sessions will become part of your clinical record. Your communication is privileged. Your therapist will keep confidential anything you say to him or her, with the following exceptions: 1) you authorize she or he to tell someone else, as in the case with insurance reimbursement, or consultation with another professionals, 2) If your therapist is ordered by the court to disclose your information, 3) If your therapist determines that you are a danger to yourself or to others, 4) If during session she or he becomes aware that there is physical abuse, sexual abuse, or neglect to a child or an aged adult. He or she is required to report to the State of Texas Protective Services. 5) Your therapist must also disclose to the proper authorities if there has been sexual abuse perpetrated by a minister or therapist, or if there has been a life threatening felony unreported. In the event of your therapist's death or incapacitation, all records will be transferred to another licensed mental health counselor.

Client Initials _____ Date _____

A notice will be placed in the Williamson County Sun and in the reception area advising clients to contact the mental health designee or the executor of the therapist's estate to have records transferred to another mental health practitioner.Any records not picked up or transferred within six months of the therapist's incapacitation or death will be destroyed by shredding and fire.

Please be aware that at this time our Boards do not consider texts or emails to be secure enough to guarantee confidentiality. Please do not send clinical information unless it is encrypted.

Initial assessments are 50-80 minutes. Individual sessions will be scheduled regularly for 45-55 minutes each. Please arrive promptly. You will be responsible for payment of your scheduled appointment unless you cancel 24 hours in advance. If you fail to cancel or no show you will be billed a $50.00 cancellation fee. If there has been an emergency please call, and then you and your therapist will discuss it during your next session. Clients will not be responsible for missed appointments due to true emergency. The office will be closed for all major holidays. Barring emergency or illness your therapist will let you know in ample time when she or he will be away from the office due to training, vacation, or family obligations. They will also provide you with the name and contact information for their on call therapist.

If you urgently require assistance and cannot reach your therapist please call the crisis hotline at 512-472-4357, Bluebonnet Trails Emergency after hours at 800-841-1255, Psychiatric Emergency Services at 512-454-3521, call 911, or go directly to the nearest hospital or call 911.

Fees are part of your therapy. Payment of your fee or co-pay by personal check, cash, or credit / debit card is due at each session. Fees are as follows: Initial Assessment $150.00, Individual $125, Couple or Family $125, Group $35 for 60 minutes, and $50 for 80 minutes. A sliding fee scale may be available to those in financial need. Returned checks are subject to a $35.00 dollar fee. After hours calls, emergencies, or outside of the office therapy will be billed at the rate of your regular fee plus 25 %, billed by the quarter hour. Reading, reviewing or responding to lengthy emails or phone calls longer than three minutes outside of your scheduled session will be billed at $125 per hour billed by the quarter hour. You will be responsible for these fees as insurance does not reimburse for this. This includes any required travel time.

Many therapists prefer to not testify in court. If you reasonably expect that your counseling will result in court related issues, it is highly recommended that you seek out a counselor familiar with and comfortable with testifying and court work. Please discuss this with your therapist. For those that do, their fees are as follows, legal evaluations and or written professional opinions or summaries for legal proceedings, consultations with your attorney or an opposing attorney, calls or emails relating to your case or conflict as well as preparation for court will be billed at $125 per hour. A fee of $150 per hour will be charged for court testimony billed by the quarter hour. A retainer of $500 will be required prior to beginning any court work. Once the retainer is exhausted it will need to be replenished in $500.00 increments. If the therapist is required to block off time for court, there will be a fee of $100 per hour. If the therapist is notified within 24 hours prior to the date that court has been postponed or delayed the therapist may waive the fee for any hour that they are able to fill. If the therapist is required to travel, all expenses will be incurred by the client. Collaborative divorce facilitation is billed at $125.00/hour.

For clients who chose to file insurance claims, please be aware that in order for your health insurance to pay for your session or to be reimbursed by your health care company, your therapist will be required to diagnose a mental health condition. Any diagnosis made will become part of your medical / insurance record. People seek counseling for many issues; not all will be covered by insurance. Private paying protects your privacy to a greater degree. You may choose to private pay in which case there is no requirement to report to your insurance company. You should consider if you may need a security clearance in the future for employment or if a diagnosis could affect your future ability to obtain life insurance. While federal law should protect personal health information it is a consideration.

Client Initials _____ Date _____

Your therapist may keep an electronic health record on hard drive or in a cloud, or may handwrite notes in a traditional file. Any and all electronic or digital personal health information is stored in HIPAA Omnibus Rule and HB 300 compliant technology. Traditional files are kept behind a minimum of two locks.

Note that your insurance policy is a contract between you, your employer, and the insurance company. Your therapist advises you to familiarize yourself with your insurance policy. All services may not be covered benefits in all contracts. Fees for these services, co-pays, and any unpaid deductibles are due at the time of service. Be sure to call the mental or behavioral health or customer service number on your insurance card and ask questions. Be aware that most insurance companies contract their mental health management out to independent companies. Health insurance policies purchased on the retail marketplace (healthcare.gov) may have different coverage. Please verify your coverage prior to your appointment.

It is your responsibility to contact your insurance carrier to request a pre-authorization number, to find out your co-pay, and if you must meet a deductible. As a courtesy your therapists may file your claim in this office. However, verification of eligibility or filing of a claim does not guarantee payment. If your personal information should change, it is your responsibility to inform us. Any changes in address, employment, marital status, or even phone number can result in denied payment. Your therapist may utilize a professional medical billing service. Your therapist and billing company will make every effort to collect on your insurance claim for services rendered by your therapist. Our office will follow protocol to ensure that clean claims are sent in a timely manner.

Your therapist may be contracted or paneled with your insurance company or employee assistance program to provide services to their members for an adjusted amount. If your insurance carrier does not pay your balance in full within 60 days, we encourage you to contact the carrier to expedite payment. If your insurance company does not pay in full within 90 days, you will be responsible for the balance of your bill at the adjusted / contracted rate, less the co-pay you may have already paid. You would then have the opportunity to pursue reimbursement from your insurance carrier. Your therapist and billing company can at your request report to your insurance carrier any payment made by you that is not subject to reimbursement. Please feel free to contact your insurance carrier to inquire as to the status of their payment procedures. By signing this you are agreeing to allow your therapist or their billing company to file your insurance claim electronically and assign your insurance benefits to your therapist.

As your care provider your therapist's relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy extended to clients, all charges are your responsibility from the date the service is rendered. Your therapist realizes that temporary financial problems may affect timely payment of your account on occasion. If such a problem arises, you must contact your therapist or their billing department promptly to establish a payment plan.

You and your therapist can discuss any questions or concerns that you may have regarding this information before proceeding. By signing below you are indicating that you have read and understand this contract, and that any questions you may have had about this statement have been answered to your satisfaction. If you would like a copy for your records, you may download and print a copy or your therapist will be happy to make a copy for you for your records.

_____ _____

Client Signature or Legal Guardian Date

_____ _____

Printed Name Relationship to Client Area Code & Phone number

_____

Address

_____ _____

Name of Client if Different from above DOB

_____ _____

Counselor's Signature Date

HIPAA Compliance

HIPAA, The Health Insurance Portability and Accountability Act was enacted by congress to protect your personal health information. It is a set of regulations about how electronic healthcare information is stored, shared, and how disclosures are made. It is intended to protect your private medical information. The State of Texas and the Texas State Board of Examiners of Licensed Professional Counselors, Social Workers, Marriage and Family Therapists, and Psychologists code of ethics have long established standards which in most cases meet and in some cases exceeds HIPAA standards. This office has and will continue to comply with all ethical and legal guidelines in the state of Texas that apply to mental health counseling, and with the enacted Federal HIPAA Omnibus regulations, Texas HB 300, and the HITECH ACT.

The following outlines circumstances in which your personal health information may be used. 1. In accordance with HIPAA, your information may only be released with your consent. 2. Your demographic information as well as diagnosis is used in secure electronic billing. Billing staff is informed of dates of service, diagnosis, your demographic information, and health insurance information. For clients who chose to file insurance claims, please be aware that in order for you to be reimbursed by your health care company, I will be required to diagnose a mental health condition. Any diagnosis made may become part of your medical / insurance record. 3. All of our sessions will become part of your clinical record. Our communication is privileged. I will keep confidential anything you say to me, with the following exceptions: 1) you authorize me to tell someone else, as in the case with insurance reimbursement, or consultation with another professionals, 2) I am ordered by the court to disclose your information, 3) I determine that you are a danger to yourself or to others, 4) If during session I become aware that there is physical abuse, sexual abuse, or neglect to a child or an aged adult, I am required to report to the State of Texas Protective Services. 5) I must also disclose to the proper authorities if there has been sexual abuse perpetrated by a minister or therapist, or if there has been a life threatening felony unreported. I keep your client file in dual locked storage. I maintain records for a period of five years from the date of the last session. All electronic data is password protected. 4. In the event any unpaid balance for services of your patient account have not been taken care of within 180 days, and no payment plan or alternate arrangement has been agreed upon, demographic information, date of service, service provided, charges paid and unpaid will be turned to a professional collection service, or reported to credit agencies. 5. When requesting additional authorizations from your insurance company (particularly HMO'S) I will be required in most cases to support my request with clinical information. 6. To ensure that I am providing quality of care, insurance companies may from time to time audit me. In the event of this, an agent of the insurance company may request access to your chart to ensure that essential paperwork is enclosed such as initial assessment, visit log, demographic information, client contract, explanation of confidentiality, treatment plan and discharge notes. 7. I may hire a medical professional to audit charts to prepare for such mentioned audits and or to provide support services as needed. No other Quality Improvement etc. will be performed on your file, by anyone other than me. Any business agent such as a medical billing service, medical secretary, or auditor are bound to strict confidentiality and are punishable by law for any infringement upon confidentiality clauses.

Thank you for choosing me as your provider. I appreciate the trust and the opportunity to work with you. If you have any questions please feel free to speak with me. Please ask questions. Once you have read and have an understanding of the above information on health insurance claims and HIPAA please sign and Date below. If you have any further questions regarding HIPAA you may visit www.hhs,gov/ocr/hipaa or call directly 1-866-6277748 or email questions to ocrprivacy@os.dhhs.gov

_____ _____

Client Signature or Legal Guardian Date

_____ _____

Printed Name Relationship to Client

Client Initials _____ Date _____

PRE-AUTHORIZED HEALTH CARE FORM

(for therapists who accept debit, credit, HSA, FSA cards)

I authorize: My Health Care Provider to keep my signature on file and to charge my account for:
_____This visit only for $_____.
copay, or insurance company's contract rate until my deductible is met, then copay only.
_____All sessions copay of $_____ Recurring charges (on-going treatments).
_____ All sessions at contract rate of $_____
_____Recurring charges (on-going treatments). No show or late cancel fees of $50.00 each, (no charge for true emergencies or illness, please discuss it with me.)
_____Balances of charges not paid by insurance company within 90 days and not to exceed $_____ .
_____Balances, resulting in incorrect copay amounts. $500.00 Court Work Retainer / Divorce Facilitation

Cards will be run for only the above checked instances, and will not be above the contracted rate of my insurance carrier.

I assign my insurance benefits to the provider listed above.

I understand that this form is valid for 4 years or until the expiration date on the credit card unless I cancel the authorization through written notice to the health care provider.

Client's name _____

Card Holder's name _____

City _____ Zip _____

VISA MasterCard Other Account # _____

Signature _____ Exp. Date ____ / ___ / _____ CVV# _____

Questions & Answers about Credit Card Pre-Authorization

Q. How does the pre-authorized payment procedure work?
A. It starts when you fill out a Pre-Authorized Health Care Form for your doctor or hospital, along with your insurance paperwork. *This form works two ways*: The form can be used to specify that insurance payments are to be made directly to your doctor or hospital. Once your health care provider receives payment from your insurance company, he/she can bill your account automatically for any fees not covered by your insurance, including deductibles and co-payments. Or, use the form to automatically bill your account for recurring visits. Simply specify on the form.

Q. May I set a limit or a ceiling for the amount my health care provider can automatically bill?
A. Yes. Just indicate the maximum amount in the appropriate section of the form.

Q. Can my provider charge my account for amounts or time periods not specified on the form?
A. No. Your doctor or hospital is only authorized to bill your account up to the maximum amount – during the specified time period that you indicate on the form.

Q. Will I receive a statement or receipt for the charges automatically billed to my card?
A. You will receive a copy of the Pre-Authorized Health Care Form from your health care provider. All authorized charges will appear on your monthly statement, just like any purchases.

Q. What types of health care procedures may I use pre-authorized payments for?
A. You can use Pre-Authorized payments for every health care visit, from routine check-ups to recurring treatments such as physical therapy, allergy and dental treatments.

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3008 Dawn Dr Ste 101 Georgetown, Texas 78628
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Client's Name: _____ Date: _____
DOB: _____ Age:_____ Sex: _____ Marital Status: _____
Client Status: _____ Employed _____F/T Student _____P/T Student _____
Work at Home/Employer: _____
Job Title: _____
Client Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____
Is it okay to leave messages? _____ __email __home __cell ___ text
May we text, email, or leave phone messages regarding appointment reminders? _____
In Case of Emergency Notify: _____
Phone: _____ Relationship:_____
Immediate Family System (Children / Siblings / Parent / Spouse / Significant Other) and ages:
_____
_____

If you would like to file with your insurance, You Must complete the following, or you will be responsible for your visits. Be sure that a copy of your current insurance card has been attached to your file.

Did you purchase your health coverage through an employer or through the retail marketplace at healthcare.gov as part of the affordable care act?
_____Employer _____Retail Marketplace

Have you called your insurance company to verify that the counselor you have chosen is covered by your plan, verify your benefits and request authorization if authorization is needed? _____
Authorization Number: _____ # Sessions: _____
Did you ask what your co-pay is? _____ Co-pay Amount: _____
Insurance Company or EAP Name: _____
Insurance or EAP Phone #: _____
Insurance Mailing Address: _____
ID # if different from social: _____ Group Number if any:_____
Primary Insured Name _____ Relation to client: _____
Primary Soc. Sec:_____ Primary Insured DOB: _____
Primary Insured's Employer: _____
Primary Insurance Holder if different from client: Address:_____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____
Is there a secondary health insurance policy? Y / N

This office does not file for secondary coverage.
Please talk with your therapists if you require additional information or to discuss secondary coverage with them.