# DENISE DENICOLO, M.S.
LICENSED PROFESSIONAL COUNSELOR

**18534 Forty-Six Parkway, Suite 4**
**Spring Branch, Texas 78070**
**(210) 865-6445**

## CLIENT INFORMATION

Name: _____ DOB: _____
Address:_____ City:_____
State: _____ Zip: _____ Home phone: _____ Cell Phone: _____
SS# _____ Email:_____
Place of Employment: _____ Driver's License # _____
Job Title: _____ Business Phone # _____
Name of Spouse/Partner (guardian of child): _____ D.O.B_____
Place of Employment: _____ Job Title: _____
In case of emergency, who should we contact? _____
Phone #: _____ Relationship to patient? _____
Party responsible for payment of services: _____
Referred by: _____

## INSURANCE INFORMATION:

Policy Holder _____ DOB: _____ SS# _____
Insurance Co. _____ Policy # _____ Group# _____
Insurance Co. Address:_____
Relation to Patient: _____ Phone: _____

***There are many reasons people choose not to use their insurance to pay for mental health services.***
*Please note that if you have insurance and choose not to use it at this time, we cannot submit claims for prior services at a later date should you change your mind about using insurance. If you choose not to use health insurance to pay for services, please check (one) appropriate box below:*

☐ I do not have health insurance and will be paying for professional services directly.

☐ I do have health insurance but am choosing not to file any claims for benefits related to these services.

## PRIMARY CARE PHYSICIAN:

Name: _____ Physician Phone # _____

**Confidentiality:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. You have the right to confidential mental health care *except* in cases where the therapist believes you might cause harm to yourself, to someone else, or if child or elder abuse/neglect is suspected. In these cases, the therapist has a duty by law to file a report with the appropriate authorities. Also, therapists are required to testify when commanded to do so by a court ordered subpoena. If you run into me, your therapist, outside of the office, I will not acknowledge you. I do this to ensure your right to confidentiality. However, if you want to greet, visit with, or introduce me to your friends or family as a friend or your therapist, that is up to you. Clients take the lead in these situations.

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Initials

**Dual Relationships:** I will avoid a therapeutic relationship with a personal friend, education or business associate and will avoid the development of a personal, education or business relationship with a therapy client. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

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Initials

**Emergencies:** Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. I will return your call as soon as possible during regular working hours and no later than the next working day. Emergency calls and telephone counseling are not covered by insurance. After hours and the weekend, please leave a message and I will get back to you the next business day. If I cannot be reached and this is a life-threatening emergency, please go to the nearest ER; do not wait for me to return your call.

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**Telephone / Internet Counseling:** Whether in crisis or not, a client may occasionally want to discuss an issue on the phone or by email. For this service there is a minimum $37.50 fee, which includes up to 15 minutes of Internet or telephone conversation. If it goes beyond that period of time, the client will be billed at a rate of $37.50 per 15-minute increments in addition. Lengthy e-mails (read / responded) will be charged a minimum fee of $37.50. Please do not assume that any e-mail sent will be read immediately as there are times I am not available to check my e-mail. Health insurance companies do not reimburse for this type of contact; therefore, the client will be personally responsible for the fee.

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**Scheduling of Appointments:** Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged $150 for missed appointments or appointments canceled without 24 hours advanced notice.** Insurance companies DO NOT pay for missed appointments. If you miss an appointment and do not contact the office about the reason, your next appointment is automatically cancelled. ***If you arrive late for your appointment, your session cannot be extended into the next client's time.*** This policy is designed to respect the time management and scheduling for all other clients and therapists impacted within the office. **Please DO NOT show up at the office without an appointment, out of respect for the time I devote to my scheduled clients. Keep in mind that you want the same respect for your own scheduled appointment.**

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**FYI about Health Insurance & Confidentiality of Records:**
This practice participates with some managed care and preferred provider health plans, but not all. If I do not contract with your insurance company, then I am an "out-of-network" provider. There may be a chance that services will be a reimbursable medical expense under your insurance company's "out of network" coverage policy. If you wish to seek reimbursement from your insurance coverage for services, I will provide you with a receipt detailing information the insurance company requires for reimbursement. Please consider what the ramifications of submitting such a claim to your insurance company might be. In order for your therapy to be considered a covered medical expense, your therapist (or "provider" in insurance parlance) must give you a mental illness diagnosis according to the DSM (Diagnostic and Statistical Manual of Mental Disorders). When this information is submitted to your insurance company, it becomes part of your permanent medical record. Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Denise DeNicolo has no control over, or knowledge of, what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position. Take this in consideration when deciding to use your health insurance to help pay for services.

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**Fee Policy for Services:**
I provide individual, couples and family therapy for the fee of $150 per session. Group therapy is $60 per session (this is not family therapy). In-home therapy sessions are $200 per hour. I charge $150 per hour for reports, letters, and other documentation. Any services I provide beyond your therapy session, or what your insurance company has authorized, are charged to you directly at my hourly rate of $150 (charged in 15-minute increments). Court preparation and appearances begin at $300 per hour. Fees for other services provided upon request. While the filing of *in-network* insurance claims is a courtesy that is extended to you, all charges are ultimately your responsibility for the date of service. All co-payments, unmet deductible expenses, and services or charges not covered by insurance are due at the time of service. Any returned checks are subject to a $40 charge. Those who have *out-of-network* benefits must pay the full fee upfront and may have the insurance company reimburse them. Scheduled appointments outside regular business hours provided solely for the convenience of the patient (before or after regular office hours) will be billed an additional $50 to your copay or

$200 for the session. Should your account be referred for collections, you agree to pay 6% interest plus a *$25* collection fee and reasonable attorney fees and/or court costs. If legal action becomes necessary, the cost of bringing the procedure will be included in the claim. If a client wants me to speak, meet, or correspond in any way with any other person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time. **Payment is due at the beginning of your session. You may pay by cash, check or credit card.**

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**Initials**

**Health Insurance Portability and Accountability Act (HIPAA)**

This Service Agreement and the accompanying Notice form contain summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new rights for patients with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

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**Litigation Limitation:**
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on Denise DeNicolo to testify in court or at any other proceeding, nor will a disclosure of client records be requested unless otherwise agreed upon.

Should I be subpoenaed to testify in court regarding an issue with a client, this will necessitate that I clear my schedule to be "on call" for the court appearance. The charge for this is a minimum nonrefundable fee of $1200, payable in advance, regardless of whether I actually testify or appear in court. The first $1200 applies to a maximum of four hours of my time at an out-of-office courtroom rate of $300 per hour. Expenses I may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at an appropriate rate and are in addition to the $1200 minimum fee. If I am required to be on call beyond the first four hours for a court appearance, an additional $1200 minimum fee will be incurred, even if I must remain (on call) one minute, one hour, or all four hours beyond the first four. In other words, a $1200 minimum fee will be charged for any portion of a four-hour time slot in which I am required to be "on call" to testify in court, whether I actually testifying or not. The client is responsible for these fees, not the court. Therefore, the client (or the parents of a minor client) will be billed in advance.

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**AUTHORIZATION AND RELEASE:**

I have read the above Statement of Understanding & Informed Consent carefully; I understand them and agree to comply. I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by the insurance company.

**Consent for Care:**

By signing this form I agree that I have read and understand these policies, give full consent for the completion of evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. I also agree that I am financially responsible for any fees that are accrued for me or members of my family, including dependents who may or may not be over the age of 18, while under the care of Denise DeNicolo, LPC. I further acknowledge that I have received notice of HIPAA policies.

**I UNDERSTAND AND AGREE TO THE ABOVE TERMS.**

**Patient's Name:**_____

_____ _____

Patient/Guardian Signature Date

_____ _____

Denise DeNicolo Date

Denise DeNicolo, LPC
**18534 Forty Six Pkwy, Ste. 4, Spring Branch, Texas 78070**
**Phone: (210) 865-6445**
**Fax: 866-838-2089**

**FORM MUST BE COMPLETED OR A $35 DEPOSIT IS REQUIRED WITH EACH VISIT**

In order to improve office efficiency, I will no longer send bills for balances not paid by your insurance company. If you are using your health insurance, your insurance company should be sending you directly the explanation of benefits.

I now require a credit card to guarantee payment of any outstanding balances. This will greatly improve office efficiency in that I will no longer have to generate and mail a bill, and you will no longer have to write and mail a check. A similar payment method is used to check into a hotel or to rent a car. A copy of the charge will be emailed to you. This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays and deductibles will still be due at the time of your visit. You may pay by check or cash at the time of your appointment and your credit card will not be charged.

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I authorize Denise DeNicolo, LPC to charge outstanding balances on my account to the following credit card: **Visa** **MasterCard**

**Account # _____-_____-_____-_____ Expiration Date: _____**

**On reverse indicate the 3 digit code: _____ Your billing zip code: _____**

**Name of card (Please print): _____**

**Email for receipt: _____**

**FORM MUST BE COMPLETED OR A $35.00 DEPOSIT IS REQUIRED WITH EACH VISIT**

**WHEN PAYING BY CHECK:** When you provide a check as payment, you authorize Denise DeNicolo LPC to use the information from your check to withdraw the amount from your account or to process the payment as a check transaction. Information from your check will be made available for the withdrawal, funds may be withdrawn from your account as soon as the same day you make payment.

I understand that in the event that my check payment is returned for insufficient funds, I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. By using my check I acknowledge and accept this policy and its terms and conditions of checXchange.

**Signature: _____ Email: _____**

# Appointment Reminders / Online Scheduling

You can receive an appointment reminder to your email, cell phone via text messages, or your home phone (via a computer generated voice message) the day before your scheduled appointment. You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit my website: www.DeniseDeNicoloLPC.com and click on the calendar on the Home page to schedule or reschedule. This will direct you to Therapy Appointment website to login. You may continue to schedule appointments in person or by telephone, but if your have Internet access, you are sure to enjoy the convenience.

Your Name: _____

Requested login name:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

Your temporary password (you can change this later):

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| H | O | L | I | D | A | Y | 1 | 2 | 3 |

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check ONE):

_____ Via a text message on my cell phone (normal text rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date