DENISE DENICOLO, M.S.
LICENSED PROFESSIONAL COUNSELOR

17080 Hwy 46 West, Ste. 111
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: ____

Referred by: ____

Medications ____________________ Purpose ____________________

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 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 # ______________________

AUTHORIZATION AND RELEASE:

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.

____ ______________________________

Signature of Patient/Guardian Date

STATEMENT OF UNDERSTANDING / CONSENT

Confidentiality:

You have the right to confidentiality in your therapy. Information concerning your therapy will not be disclosed without your prior written permission except for the following legal exceptions:

1. Life or safety of you or someone else is seriously threatened.
2. There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3. Court ordered treatment.
4. An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5. I have the right to report animal cruelty to appropriate authorities.

Emergencies/Telephone Counseling:

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 on 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.

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 $50 for** missed **appointments or appointments canceled without 24 hours advanced notice.** Insurance companies DO NOT pay for missed appointments. Exceptions to this policy may be made for unforeseen emergencies, but must be discussed on a per case basis with the therapist. If you miss an appointment and do not contact the office about the reason, your next appointment is automatically cancelled. ***If you arrive more than 15 minutes late for your appointment, your session cannot be extended into the next client's time; therefore, you will be charged as a missed appointment ($50). Insurance companies will not pay for sessions less than 45 minutes).***

Fee Policy:

While the filing of 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 $25 charge. Those who have out-of-network benefits must pay the full fee upfront and have the insurance company reimburse them. 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.

Fees for Services:

I provide therapy for the fee of **$100 per 50 minute session**. I charge $100 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 $100 (charged in 15-minute increments), to include phone calls exceeding 5 minutes. Court appearances begin at $200 per hour. Fees for other services provided upon request.

Consent for Care:
I give full consent for the completion of my evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. If I have any questions about the following information or about anything related to my therapy, I will discuss this with the therapist.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

Patient's Name:____

____ ________________________________
Patient/Guardian Signature Date

____
Print name