

# FACE SHEET

Initial Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## CLIENT INFORMATION

First Name: \_\_\_\_\_ Initial: \_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Sex: \_\_\_\_ Marital Status: \_\_\_\_ How did you hear about us: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer or School: \_\_\_\_\_ Full Time \_\_\_\_ Part Time \_\_\_\_

Circle The Preferred Phone Number: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_ Religion: \_\_\_\_\_

## PAYMENT INFORMATION (we will need a copy of insurance card and photo ID)

Full name of Insured: \_\_\_\_\_ DOB: \_\_\_\_ Sex: \_\_\_\_

SSN: \_\_\_\_\_ (*Insured person's social security number is required*)

Address of Insured: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Client's relationship to insured (circle): Self Spouse Child Other: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

CIRCLE CONTACT PHONE OF YOUR CHOICE: Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Is there a secondary insurance policy (circle) Yes No I don't know

## EMERGENCY CONTACT:

Full Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Full Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to client: \_\_\_\_\_

**CONFIDENTIAL CLIENT INFORMATION**

**Client Name:** \_\_\_\_\_

Children or Siblings (name, ages): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving treatment for an illness, injury, or other medical condition? Yes No  
If yes, what is the diagnosis and what are the treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any prescription or over-the-counter medications or illegal drugs? Yes No  
If yes, please tell us the name and dosage of each medication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, bankruptcy, juvenile delinquency): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of person completing this page      Date      Circle: Self Parent Spouse Other  
Your relationship to client

## PRE-AUTHORIZATION FOR HEALTH CARE

### CONSENT FOR TREATMENT

By signing this document, I, \_\_\_\_\_, am indicating that I agree to participate in the following services with Sarah K. Mabe, LPC-Intern:

_____ CLINICAL ASSESSMENT	_____ INDIVIDUAL THERAPY
_____ CLINICAL ASSESSMENT FOR MY CHILD	_____ THERAPY FOR MY CHILD
_____ FAMILY THERAPY OR COUPLE/RELATIONSHIP THERAPY	_____ GROUP THERAPY
_____ OTHER _____	

I understand that, in order to develop the therapist-patient relationship and treatment plan necessary to meet my needs, an initial assessment will be completed and a joint decision made to either proceed with the recommended treatment plan or to continue the assessment over additional visits. The limitations and benefits of all therapy or services I may receive will be discussed with me. I understand that while the long term goal of therapy is to feel better, I may experience a period of feeling worse before I begin to feel better and I also understand that there is no guarantee of success. I understand that there may be alternative methods of therapy for my consideration and I am encouraged to ask questions regarding my treatment or other methods at any time.

### PRIVACY (CONFIDENTIALITY) POLICY

State and federal laws protect the confidential nature of the therapist-client relationship. Clinical information will not be released to anyone without prior written consent to do so by the client (or the guardian-parent of a minor). However, there are some exceptions where information may be released without client consent. These include:

- 1) A therapist must take appropriate action when there is a danger to the client or to another individual at the client's hands. In general, this means that the therapist may involve others to protect the client if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival. Others may also be involved to prevent harm to another person. State law mandates that suspected neglect or abuse of a child, of an elderly individual, or of a disabled individual must be reported.
- 2) When ordered by a court to do so, a therapist may testify or release client records. However, no release of information or testimony is given in response to a subpoena without the client or client guardian's written authorization unless required by law to do so.
- 3) Consultation with other health care professionals may be necessary at some point in time. Where possible, identification of clients is withheld. However, there are times when exchange of information is necessary. An example of this type of exchange would be when the therapist is out of town or on vacation and another therapist is providing coverage for that therapist. Case material is often used for training, for research, and for other academic endeavors but client identification is always removed. Any other release of information must come with the above listed written approval.

I understand that this agreement is valid for the duration of time that I am participating in services with Sarah K. Mabe, LPC-Intern (hereinafter referred to as SKM). By signing below, I acknowledge that I have received a copy of the **Pre-Authorization for Health Care** and the **Privacy (Confidentiality) Policy**, and I understand and agree to the entire contents of those documents. I acknowledge that I have had an opportunity to have answered any questions, comments or concerns that I might have had prior to signing this consent and participating in services. I am aware that I can stop counseling at any time. SKM reserves the right to amend the **Pre-Authorization for Health Care** and the **Privacy (Confidentiality) Policy** and changes will be available at the office of SKM. I can request a copy of changes at any time at no charge. Any changes that SKM makes are effective immediately unless otherwise indicated. **A COPY OF THIS PAGE MAY BE FOUND ON THE LAST PAGE.**

\_\_\_\_\_  
CLIENT SIGNATURE (18 and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE OF PARENT OR SPOUSE  
(for a child age 17 or younger)

\_\_\_\_\_  
Date

**Notice of Financial Responsibility**

I understand that I will be charged \$90 for an initial session, \$75 for each 45-60 minute session, \$112.50 for each 75-90 minute session, \$37.50 for each 20-30 minute session, \$75 per hour for telephone support prorated in 15 minute increments, \$50 per hour report writing, and various other charges as needed for consultation etc. with others. I am aware that State and federal laws require SKM to collect co-payments, co-insurance and deductibles in full. **I am responsible for paying my co-payment at the time of my session.** SKM will bill me for co-insurance and deductibles that are due after SKM files with my insurance company and receives an explanation of benefits.

If SKM is an in-network provider for my insurance company, I am only responsible for the contracted rate which may be the same or less than SKM's rates for services. If SKM is an out-of-network provider, I may be responsible for the difference between what my insurance pays and what SKM charges. I am aware that SKM *may* charge me interest if I am under a payment plan. **If I do not give 24 hours notice of a cancellation or if I miss my appointment, I will be charged the full session fee.** After receiving an Explanation of Benefits from my insurance company, or if I am paying privately, if my balance exceeds \$200, my counselor may stop providing services until my balance is down to a reasonable amount. I understand that services may not be provided if my account is turned over to an attorney or other agency for collection.

**I am aware that there is no guarantee that my insurance company will cover services, and that I am fully responsible for all fees not covered by my insurance company.** I understand that payment may be made with cash or by check. SKM does not extend credit. In any such arrangement, late payment fees of \$10 per month will be charged on any balance not paid within 30 days. SKM does not depend on an outside collection service unless accounts are overdue by 90 days. SKM would much rather communicate with patients and find solutions to overdue accounts. I hereby consent to the delegation of collection activities to an outside collection agency, including the release of necessary information required by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. There is a returned check processing fee of \$25 in addition to reimbursement for charges assessed by SKM's bank. Statements, receipts, or other documentation will not be issued to any delinquent account until paid in full. I agree that SKM reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I will have 30 days to decide if I will continue services with SKM under the amended agreement. I authorize payment of benefits to SKM for any and all services provided by SKM.

**COURT APPEARANCES:** I understand that if report preparation is requested or required, the time rate charged for our therapy sessions will apply. Extended or frequent telephone contact will also be charged for. These services are not usually reimbursed by insurance. I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are \$75 per hour including travel and waiting time, are non-discountable, and are payable in advance only. A four hour minimum (\$300) is required and must be paid prior to any testimony, provision of a clinical opinion, response to attorneys via telephone call or mail, subpoenas, or preparation of any report for litigating parties.

\_\_\_\_\_  
Signature of client of Parent of child under 17

\_\_\_\_\_  
Today's Date

**RELEASE OF INFORMATION:** I authorize any and all of my medical information necessary to process insurance claims to be released to \_\_\_\_\_ for the purpose of processing claims. This authorization to release information shall be valid through December 31, 2010.

\_\_\_\_\_  
Signature of client of Parent of child under 17

\_\_\_\_\_  
Today's Date

My co-payment or co-insurance due at the time of each session is \$\_\_\_\_\_ . My deductible is \$\_\_\_\_\_

## ABOUT SARAH K. MABE, LPC-INTERN

Please initial each box:

- I understand that Sarah K. Mabe is a Licensed Professional Counselor-Intern in the state of Texas
- I understand that Sarah K. Mabe works with children, adolescents, and adults in individual, group and family counseling.
- I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.
- I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to Sarah K. Mabe about this.
- I understand that Sarah K. Mabe does not perform formal testing but refers individuals to those who do.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Sarah K. Mabe to tell someone else in writing or verbally, b) Sarah K. Mabe determines that her client poses a threat to themselves or others, c) she is ordered by a court to disclose information, or d) she suspects that child abuse has taken place, at which time she will notify Child Protective Services.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that if I have a complaint I can not resolve with Sarah K. Mabe and I wish to file a formal complaint, I may contact the Texas Sate Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Sarah K. Mabe.
- I understand that there is a returned check fee of \$25 and that if a returned check is not cleared up in 30 days, Sarah K. Mabe will file a suit with the Comal County District Attorney's Office.
- I understand that all co-pays are due at the time of service.
- I understand that if I do not give at least 24 hours notice in canceling an appointment, I will be charged a fee equal to that of the scheduled appointment. This amount, which will not be covered by insurance, will be due not later than the next scheduled appointment.
- I understand that the rate for an initial session is \$75.00 and \$75.00 for subsequent routine sessions. These fees are for a 45 minute session.
- I understand that Sarah K. Mabe is not a psychiatrist, she is a Master's level therapist, and as such can not recommend or prescribe medications but can encourage clients to see an MD for a medication evaluation.
- Emergencies: I understand that although Sarah K. Mabe does not provide formal emergency services, she does wish to be available to the extent possible. I may call the office number at any time and leave a message. If during the business day, this call will be returned fairly quickly in most circumstances. If the call is received over night or on the weekends, it will usually be returned the next business day. If I find myself in an urgent situation, I have the choice of waiting for the return call, of calling 911, or of going to the nearest emergency room for immediate care.
- Death or Incapacity: I understand that in the event Sarah K. Mabe dies or becomes unable to continue providing clinical services, Jay L. Jeter, LPC will be designated as conservator for my patient records and he will take possession of said records at that time. Upon receipt of my written request , Jay L. Jeter, LPC will make these records available to me or a mental health provider of my choice.

**By signing below, I confirm that I have read, agree to, and received the above information.**

\_\_\_\_\_  
*Client/Parent of Client*

\_\_\_\_\_  
*Date Received and Read*

This copy is for you to read, understand, sign and leave with Jay Jeter.

## **ABOUT SARAH K. MABE, LPC-INTERN**

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**PRE-AUTHORIZATION FOR HEALTH CARE**

**CONSENT FOR TREATMENT (Client Copy)**

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- |   |                            |
|---|----------------------------|
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| _____ CLINICAL ASSESSMENT FOR MY CHILD              | _____ THERAPY FOR MY CHILD |
| _____ FAMILY THERAPY OR COUPLE/RELATIONSHIP THERAPY | _____ GROUP THERAPY        |
| _____ OTHER _____                                   |                            |

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Date

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SIGNATURE OF PARENT OR SPOUSE  
(for a child age 17 or younger)

\_\_\_\_\_  
Date