FreeYour Mind Professional Counseling Services, PLLC
4801 Woodway Dr. Suite 300 East Houston, Tx 77056
Nakeisha Q. Washington M.A.,LPC-S/NCC
Phone#832-850-6422
Fax: 832-850-7852

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/ _____/					
CLIENT INFORMATION					
Client's Last Name	First	Middle	○ Mr. ○ Ms. ○ Mrs. ○ Miss		Marital Status (Circle One) Single / Married / Other/NA minor
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Gender ○ Male ○ Female ○ Other _____
Street Address					
	City	State	ZIP Code	Social Security	*Please note which number office can use to make session reminder calls*

					Home Phone–reminder calls Y/N
P.O. Box					
	City	State	ZIP Code	Cell Phone-reminder calls Y/N	
Occupation				( )	
		Work Phone-reminder calls Y/N			

		( )			
Referred to Provider by (Please check one box & list)	O Dr.	O Insurance Plan	O Website	O Yellow Pages	
O Family	O Friend	O Other			Closer to Home/ Work
Email Address: - can email session reminders be sent to this address O Yes O No		Alternative Email Address:			

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)**		
Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
	/ /		
Email Address:			
			Cell Phone No. ( )
Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? O Yes O No Is this an EAP visit? O Yes O No
Total Annual EAPs allowed _____

Please Select Your Primary Insurance Provider

Insurance Phone # _____	○ CHiP/Star/Starplus ○ TMHP ○ TCHP ○ CPS ○ Blue Cross/Blue Shield ○ Optum/UHC ○ Cigna ○ APS ○ Deer Oaks ○ Magellan ○ Humana ○ Amerigroup ○ Molina ○ Medicaid HMO_____ ○ WPO ○ MHN/MHNet ○ Aetna ○ PAS ○ TriCare/TriWest ○ ACI ○ Life Synch/Humana ○ Value Options ○ Other ○ Cenpatico/Superior HC ○ Lifeworks/ Ceridian ○ Compsych ○ EAP _____
What is the authorization number?	○ Self-Pay

Insured's Name	Insured's S.S. #	Birth Date	Group #	Policy #	Co-Payment
		/ /			$
Client's Relationship to Insured	○ Self	○ Spouse	○ Child	○ Other	

Name of Secondary Insurance (if any) applicable)	Insured's Name	Group #	Policy #		
Client's Relationship to Insured	○ Self	○ Spouse	○ Child	○ Other	

IN CASE OF EMERGENCY

Name of Local					
address)	Client	No.	Work Phone No.		

Copy of insurance card on file Y/N

Copy of Driver's License on file Y/N

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY		
I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Free Your Mind Professional Counseling Services, PLLC will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.		
X	CLIENT/GUARDIAN SIGNATURE	DATE
I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.		
X	CLIENT/GUARDIAN SIGNATURE	DATE
I hereby authorize the release of necessary medical information for insurance reimbursement purposes.		
X	CLIENT/GUARDIAN SIGNATURE	DATE
I authorize the payment of medical benefits to the provider of services.		
X	CLIENT/GUARDIAN SIGNATURE	DATE

CLIENT GUIDELINES & GENERAL INFORMATION

Client Name:_____ **Record #:** _____

Rates and charges:

As with any type of treatment, charges depend on the number of days and types of services you receive while you are engaged in a therapeutic relationship with **Free Your Mind Professional Counseling Services, PLLC .** You are expected to make satisfactory arrangements for payment of your treatments. A Sliding Fee scale is available upon request for clients who do not have insurance or for clients who do not qualify for Medicaid. The sliding fee amount payable is based on the amount of household income and the number of family members that are living in the household. Proof is required (i.e. last two paycheck stubs or a copy of the last year's w-2 form). The basic fee for individual counseling is **$175.00** per therapeutic hour. **In the event a scheduled appointment is missed or canceled in less than 24 hours prior to appointment time, the client is still responsible for payment of $75 and $250 for individuals on any type of leave or FMLA for no show/late cancel. All payments are due proceeding every session. Free Your Mind Professional Counseling Services,**_____ _____

PLLC and client agrees to the amount of: __ _____

$175/therapeutic hr

(See attached payment Contract for Services) on the following page.

Assignments:
Completing all assignments is your responsibility, and you are expected to assume Responsibility for these assignments.

Smoking:
No smoking is permitted during treatment activities or any place in the facility or on the premises.

Drinking/Drugging while in treatment:
The use of mood-altering chemicals is not allowed while you are a client at **Free Your Mind Professional Counseling Services, PLLC**

Weapons:
Weapons, including but not limited to firearms and illegal knives are not permitted on the premises. If weapons are found in your possession authorities will be notified.

_____ _____
Client's Signature Date

_____ _____
Therapist Signature Date

LATE/CANCEL/NO SHOW POLICY

Free Your Mind Professional Counseling Services, PLLC charges a fee of $75 and $250 for individuals on any leave of absence or FMLA, when scheduled therapy sessions are not canceled within 24 hours of the appointment time either by email at "www.fympcs.com" via the client portal, www.therapistsrock@fympcs.com or by phone at 832-850-6422 except in the case of an extreme emergency.

My signature acknowledges that I understand this policy and agree to adhere by these guidelines.

_____ _____
Client signature **Date**

_____ _____
Clinician signature **Date**

Payment Contract for Services

The following is a statement of the financial policy. It is requested that you read and sign this statement prior to beginning services. Full payment is due at the time of service. Payment methods include: Cash, Check, Visa/ MasterCard/ Discover. A $35.00 fee will be accessed to your account for all returned checks.

FEDERAL TRUTH IN LENDING STATEMENT FOR PROFESSIONAL SERVICES

Part One: Fees for Professional Services

$ 175 per visit (defined as 50minutes)
$ 75 is charged for missed appointments or cancellations with less than 24 hours notice. $250 for individuals on any leave of absence or FMLA.

Part Two: All Clients

Payments and related fees are due at the time of service. Services will be terminated if timely payment is not made as agreed to by this consent. There will be no exceptions made to this agreement.

Part Three: Minors

The adult accompanying a minor (or Guardian of the Minor) is responsible for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service or other

arrangements have been made.

I HEREBY CERTIFY that I have read and agree to the above terms and conditions and accept full responsibility for payments of all fees at the time of the visit, unless other arrangements have been made.

Clients Name:_____DOB: _____

Person responsible for account: _____

PAYMENT AUTHORIZATION FOR SERVICES

I authorize Free Your Mind Professional Counseling Services, PLLC to keep my signature on file and to charge my credit card account for:

□ All balances not paid by insurance or other third-party payers after sixty days.
□ Recurring charges (session fees, co-pays) as per amounts stated above.
All credit card payments are deemed final.

Client's Name:	**Cardholder's Name:**
Cardholder's Billing Address:	
Card Type:	**Expiration Date:**
Account Number:	**Security code:**
Cardholder's Signature:	**Date:**

INFORMED CONSENT TO TREATMENT (Adult)

Client Name:_____Record # _____

Free Your Mind Professional Counseling Services, PLLC is comprised of therapeutic services targeting family relationships and individual functioning. The overall program goal is to provide outpatient therapy/ counseling for individuals and families experiencing stress or problems in relational, life cycles and general interpersonal functioning. The specific service objectives of the therapy are:

to provide culturally sensitive, family-focused assessment and treatment planning for individuals (children and adult) and families:
to promote family- focused treatment to resolve those problems identified through the assessment;
and to provide clients with referrals for any needed services not available within the program.

A variety of treatment services are available, including individual and family therapy. All information obtained during your contacts with the agency is confidential within the limits of the law. Payment of the services is required prior to the beginning of the session. Please remember that payment for service is your obligation regardless of insurance or other third-party involvement. If prior arrangement has been made and you are paying your fee by check, please remember that there is a **$35.00** fee for all insufficient checks.

Consent to Treatment
I am entering to this therapy contract with full understanding, participation, and consent, I have read the Information provided by the therapist on the company website, and I have also signed the additional forms i.e. confidentiality, grievance, etc. I understand that I have a right to a second opinion from another mental health professional at any time and register a legitimate concern with an appropriate to agency as indicated in the information page.

_____ _____
Clients Signature Date

Therapist Signature Date

CONFIDENTIALITY

To: All Clients **Record #** _____

Communication between the therapist and client and the clients records however created or stored are confidential under the provisions of the **Health and Safety Code, Chapter 611** and other state or federal statutes or rules where such statutes or rules apply to a licensee's practice.

The Therapist shall not disclose any communication, records or identity of clients except as provided in the **Health and Safety Code, Chapter 611** or other state or federal statutes or rules.

A Therapist shall comply with the **Texas Health and Safety Code, Chapter 611**, concerning access to records.

All Clients are protected under these statutes from disclosure to other persons as to their whereabouts and diagnosis.

There are other instances where the Disclosure Act applies such as in release of Treatment Records and insurance matters. **Free Your Mind Professional Counseling Services, PLLC** will explain these instances and have you fill in the proper forms only if this becomes a problem.

Confidentiality does not apply in cases where a court order is received or when the client is a danger to himself/herself or others.

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date

CONSENT TO LIMITS OF CONFIDENTIALITY

To: All Clients **Record#** _____

(Note: In all instances this form must conform to the statutes in the state in which you are practicing)

Confidentiality generally means that anything that occurs in psychotherapy is not divulged by the therapist. Generally, this is true, although there are some commonsense and some not-so-commonsense situations that are exceptions to this rule. I have read the information brochure and understand the reasons for these exceptions. I also understand that privilege means the client's ability to protect information in a legal proceeding. With this background, I consent to the following:

Exceptions to Confidentiality and/or Privilege:

Mandated reporting
If I am a danger to myself physically or incompetent mentally, as determined by the therapist's evaluation
If I intend to bring physical harm to others
If I have physically, sexually, or (severely) emotionally harmed or neglected a minor or a dependent adult

Situations in which privilege does not apply or is limited

If I bring a lawsuit against this Therapist
If another person is in the room
If a court requires me to testify
If I am being evaluated for a third party

Items 1, 2, and 3 above are extreme situations that are exceptions to confidentiality and in which the therapist **MUST** file a report with the appropriate agency. All other reasonable means are exhausted before this option is used: even then, your cooperation is encouraged.

Disclosure of information
In a commonsense fashion, any time you give permission to provide information to another party, there is limited confidentiality. In these cases, and in most situations listed above, the therapist can reveal information only to someone who has a need to know, and the entire records or irrelevant information may not be disclosed. Whenever information will be shared with other persons, their names or positions will be specifically listed, and every effort will be made to ensure that the receiving person also maintains confidentiality. The major situations in which the therapist may disclose such information with permission are:
If I am being evaluated or treated for a third party (disability, custody, etc.)
If I request or give permission for information to be obtained from or provided to a third party (therapist, physician, teacher, employer, etc.)
If my therapist is unavailable and temporary coverage is required (emergencies, vacations, etc.)
If my therapist is being supervised, the supervisor may know the details of the case, and is also bound by confidentiality
If I am using third-party coverage (insurance0 to pay for therapy
In the event of my therapist's disability or death

_____ _____
Client's Signature **Date**

_____ _____
Therapist's Signature **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

Please fill out this form completely: Incomplete forms are invalid and are not permissible.

Client's Name_____**Record #** _____
Last Name **First Name** **Middle Initial**
Address _____

Birth Date_____**SSN** _____

This will authorize:

Business Name: Free Your Mind Professional Counseling Services, PLLC
Phone # 832-850-6422
Address 4801 Woodway Drive Suite 300 East Houston TX 77056

To Release To:

Name_____Phone_____

Address _____

The following information (choose one): ○ **Via Mail** ○ **Via Fax** ○ **Patient pick up**

□ **ONLY THE FOLLOWING INFORMATION: (Specify the dates of service or condition)**

_____

_____

_____

□ **COUNSELING & THERAPY INFORMATION:** To include HIV/AIDS information_____Initial
Drug & Alcohol information_____Initial

For the purpose of:

_____

_____

Authorization: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying Free Your Mind Professional Counseling Services, PLLC in writing. I understand that any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider; the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative processing fee.

_____ _____
Signature of Patient/Client (or Legal representative) Date
If Legal Representative, Relationship to Client _____

_____
Signature of Witness

ADDITIONAL FEES FOR SERVICES

To: All Clients
Record # _____

The structure for services is designed primarily for face to face counseling and therapy. However, there are times when client's needs extend beyond the traditional services. In these cases, please be advised of the following payment schedule. *(Services beyond counseling and therapy are not billable to insurance companies and are therefore the client's responsibility.)*

All fees are due at the time services are rendered, unless previous arrangements are made in advance.

I agree to the following fees:

■ Regular **Fee - $175.00/hr** **Fee/Co-Pay** $_____/hr
■ Intake assessment **Fee-$250**

■ Report**/Letter Preparation-$250**

■ ***(ALL** FMLA paperwork including /Short/Long- term Disability/Accommodations / and/or other medical leave paperwork, school/job letters, etc.)* ***No exceptions!*** **$100.00/hr** and or up to **$80.00(per packet)**

■ **$40.00(per** Notes-Fax/Email/Per medical record Request-Submission

■ Telephone **Calls** **$100.00/hr**
(*Consults with Clients /Parent(s) exceeding 10 minutes in length*)

■ Consultation **with other Professionals** **$100.00/hr**
(Lawyers, Doctors, Therapists, etc.) As requested and /or approved by client/Parent(s) *(Including travel time if not by phone)*

■ Home **Visits** $200.00/hr

■ Court **Testimony** $200.00/hr/$600 Deposit
(Including preparation time, travel, reports, waiting and testimony)

_____ _____
Client's Name Date

_____ _____
Responsible Party Signature Date

_____ _____
Therapist Signature Date

COORDINATION OF BENEFITS

Please complete the information below. If you have any questions regarding this form, please contact your Insurance Company's customer service department at the address on the back of your insurance card.
Your policy could have a `coordination of benefits` provision which allows your Insurance Company to share responsibility in covering health care expenses with any other Insurance company covering you or your family for medical benefits. When health care expenses are shared between two or more companies, out of pocket expensed for the participant may be reduced. In addition to benefiting the individual participant, coordination of benefits is beneficial to all participants because it avoids duplication of payments which would result in higher premium rates.

1. Employee_____ Date of Birth _____

2. Employer Name_____ Account Name _____

3. Social Security Number / Alternative Participant Number _____

4. Patient Name_____ Patient Date of Birth _____

5. Patient Address _____

If Married. Complete the following:
Name of Spouse or Employee _____ Date of Birth _____

Spouse's employer and address _____

Is spouse covered under his/her employer's health plan? Yes___ No ____

If yes, please complete the following:
Employer's health plan Name _____

Address for submitting claims _____

Policy Number_____ Effective Date _____

Single coverage_____ Family Coverage _____

If Family coverage, list all covered members _____

If you are divorced and / or remarried with dependents, please complete the following:

Dependents	Person with Physical Custody	Relationship	Person Responsible for dependent healthcare expenses per divorce decree

If you or your family members are covered under any other medical plan in addition to the coverage listed above (i.e. Medicare or Medicaid, other insurance), please complete the following section.
(This does not include the employee's current insurance plan.)

Health Plan Name	Name of Person Covered	Policy Number	Effective Date

I certify that the above information is true and correct. I understand that the purpose of this information is to assure the appropriate coordination of benefits of all plans.

_____ _____
Policy Holder/Patient Signature Date

CLIENT GRIEVANCE PROCEDURES

To: All Clients **Record #** _____

Free Your Mind Professional Counseling Services, PLLC wishes to ensure that your rights are respected, and that all complaints are resolved. As a client, you have the right to voice all complaints and recommended changes in policies and services offered by the program without fear of restraint, interference, coercion, discrimination or reprisal.
You may express to the therapist, either verbally or in writing, all complaints about any issue, including complaints of abuse, neglect and/or exploitation.
The therapist will respond to your complaint within 2 days (72 hours on the weekend), to answer any questions you may have about client rights or to assist you in filing grievances.
Free Your Mind Professional Counseling Services, will in no way restrict, discourage, or interfere with your communication with an attorney or with the **Texas State Board of Examiners of Professional Counselors** for purposes of filing a complaint.
If you wish to call your attorney or the **Texas State Board of Examiners of Professional Counselors**, **Free Your Mind Professional Counseling Services,** will provide the telephone for your call.
If you wish to write your attorney or the **Texas State Board of Examiners of Professional Counselors**, **Free Your Mind Professional Counseling Services, PLLC** will provide you with paper, a pen, and a postage paid envelope for your convenience. If you are unable to write or need help in writing a complaint, a staff member will provide the help you need.
You may file your complaint directly, either by phone or in writing to:

Executive Secretary
Texas State Board of Examiners of Professional Counselors
1100 west 49th Street
Austin, Texas 78756-3183

LPC Board Office:
1-512-834-6658
Or
Complaint Hotline:
1-800-942-5540

Client's Signature	**Date**
Therapist's Signature	**Date**

Free Your Mind Professional Counseling Services, PLLC

FreeYour Mind Professional Counseling Services, PLLC
4801 Woodawy Drive Suite 300 East Houston, Tx 77056
Nakeisha Q Washington M.A.,LPC-S/NCC
Office: 832-850-6422
Fax: 832-850-7852