FACE SHEET

Initial Appointment Date: ____/____/_____

CLIENT INFORMATION

First Name: _____ Initial:____ Last Name:_____

Date of Birth:_____ Social Security No.:_____

Gender: _____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:_____

Name and Address of Physician:_____

_____

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 second insurance policy (circle) Yes No I don't know (*If yes, we will need a copy of that insurance card.)*

EMERGENCY CONTACT:

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.

_____ _____ Circle: Self Parent Spouse Other

Signature of person completing this page Date Your relationship to client

COMPLAINTS

It is always my goal to provide professional and ethical services. If you are ever dissatisfied with my services, I encourage you to discuss it with me first to see if I can resolve your concern. However, if that is not satisfactory to you, you are also welcome to contact the Texas State Board of Examiners of Professional Counselors at the following address: 1100 West 49th Street Austin, Texas 78756-3183 1(800)942-5540

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 Kim Lehmann, LPC:

____	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 KimLehmann, LPC (hereinafter KL). 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. KL 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 KL and on The Springs Counseling Group website at www.TheSpringsCounseling.com. I can request a copy of changes at any time at no charge. Any changes that KL 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 Date
(for a child age 17 or younger)

Notice of Financial Responsibility

I understand that I will be charged $130 for an initial 60 minute individual session, $110 for each 45 minute individual session, $130 for each 45-60 minute couples session, Saturday sessions are $130, and $130 per hour for telephone support prorated in 15 minute increments, and various other charges as needed for consultation etc. with others. I am aware that State and federal laws require KL to collect co-payments, co-insurance and deductibles in full. **I am responsible for paying my co-payment at the time of my session.** KL will bill me for co-insurance and deductibles that are due after KL files with my insurance company and receives an explanation of benefits.

If KL is an in-network provider for my insurance company, I am only responsible for the KL contracted rate which may be the same or less than the KL rates for services. If KL is an out-of-network provider, I may be responsible for the difference between what my insurance pays and what KL charges. **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. If I cancel within 24 hours prior to the appointment, a lesser fee will be charged. This notice must be during the Monday to Friday workweek, not over a weekend.** 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, credit card, or by check. KL 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. KL does not depend on an outside collection service unless accounts are overdue by 90 days. KL 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 the KL bank. Additionally, there is a charge of $25 if a credit card fails to clear on its first attempt. Statements, receipts, or other documentation will not be issued to any delinquent account until paid in full. Payment by credit cards will be in accordance with the **Pre-authorization for Health Care** form provided by KL. I agree that KL 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 KL under the amended agreement. I authorize payment of benefits to KL for any and all services provided by KL.

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. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350.00 an hour for any preparation and attendance at any legal proceeding. Professional fees for court appearances, depositions and attorney consultations including travel and waiting time, are non-discountable, and are payable in advance only. A four hour minimum ($1400) 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 OR 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.

_____ _____

Signature of client OR 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 $_____

CREDIT CARD INFORMATION AND AUTHORIZATION

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be charged at my full hourly rate, and this will not be covered by your insurance. If I do not hear from you before your missed appointment, your credit card will be charged. If you need to cancel or are going to be late, please call me at my office number 830-608-3137. If you arrive late, the session will still end at the scheduled time. If I haven't been informed that you will be late and you haven't appeared 15 minutes after your scheduled time, I may leave the office. Failure of your credit card to be accepted on the first attempt will result in a $25 fee.

Credit Card Authorization Form

I, _____, hereby authorize Kim Lehmann, LPC to bill my credit card as listed below for professional fees for [ ] myself or _____.

I agree that Kim Lehmann, LPC may bill my credit card at the full fee of $_____ for professional services including the following:

(Initial)
_____ Appointments that I elect to pay by credit card.
_____ Missed appointments. (Will be charged at the full fee)
_____ Appointments I have cancelled with less than 24 hours' notice. (Full fee)
_____ Telephone consultations (billed in 15 minute increments based on $130 per hour)

I also agree that my credit card may be charged for the following:
_____ Balances of charges not paid by me or my insurance.
_____ Insufficient funds/returned checks and bank charges for those.

Type of Card: (check one):

[ ] Visa [ ] MasterCard [ ] Discover [ ] American Express

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____

CVV2/CID Security Code: _____

Zip code on billing address: _____

Signature: _____

Date of Signature: _____

Charges will appear on your credit card statement as Kim Lehmann, LPC.

Please circle ALL of the following items that are currently a concern to you regarding YOU AND/OR YOUR PRESENT RELATIONSHIP.

1. Premarital Counseling
2. Marital relationship
3. Remarried relationship
4. Poor communication
5. Sexual difficulties
6. Parenting concerns
7. Anxiety
8. Depression
9. Family relationships
10. Excessive alcohol/drug use
11. Stress
12. Self-esteem
13. Physical problem
14. Suicidal thoughts
15. Suicide Attempt
16. Incest
17. Childhood Emotional abuse
18. Childhood Physical abuse
19. Childhood Sexual abuse
20. Financial concerns
21. Anger
22. Grief/Loss
23. Work related concerns
24. Illness
25. Physical Abuse/Violence
26. Verbal Abuse/Violence
27. Eating Disorder
28. Cutting/Self-Mutilating Behaviors
29. Rape
30. Divorce Contemplation
31. Divorce Recovery
32. Custody issues
33. Other (please describe) _____

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

_____ _____

Signature of person completing form Date

Please circle ALL of the following items that are currently a concern to you regarding YOUR CHILD OR CHILDREN (IF APPLICABLE). ____ NOT APPLICABLE

1. Stealing
2. Poor communication
3 Physical violence
4. Fire setting
5. Truancy
6. Drugs/alcohol
7. Adolescent pregnancy
8. Sexual abuser
9. Sexual abuse victim
10. Physical abuse victim
11. Divorce adjustment
12. Death/loss/grief
13. Anger
14. High anxiety
15. Peer Relationships
16. Poor Self Esteem
17. Bedwetting/Soiling
18. Destructiveness
19. Issues with Stepchildren/Step-parenting
20. Disobedience
21. ADD/ADHD
22. Depression
23. Eating Disorder
24. Cutting/Self-Mutilating Behaviors
25. Suicide Attempt

Please use the section below to list / describe the various strengths and positive attributes your child possesses:

_____
_____
_____
_____
_____
_____

Please note, for legal reasons, if you are divorced, you MUST provide a copy of the Divorce Decree before your child receives services.

ABOUT THE SPRINGS COUNSELING GROUP AND KIM LEHMANN, LPC, NCC

Please initial each box:

☐ I understand that Kim Lehmann is a Licensed Professional Counselor in the state of Texas

☐ I understand that Kim Lehmann 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 Kim Lehmann about this.

☐ I understand that Kim Lehmann 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 Kim Lehmann to tell someone else in writing or verbally, b) Kim Lehmann 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 Kim Lehmann 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 Kim Lehmann.

☐ I understand that there is a returned check fee of $25 and that if a returned check is not cleared up in 30 days, Kim Lehmann 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 $130.00 and $110.00 for subsequent routine sessions and $130 for all couples sessions. Saturday sessions, if available, are $130. These fees are for a 45 minute session.

☐ I understand that Kim Lehmann 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 Kim Lehmann 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 Kim Lehmann dies or becomes unable to continue providing clinical services, Kristin Butler, 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, Kristin Butler, 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 Kim Lehmann.

ABOUT THE SPRINGS COUNSELING GROUP AND KIM LEHMANN, LPC, NCC
(Client copy)

Please initial each box:

☐ I understand that Kim Lehmann is a Licensed Professional Counselor in the state of Texas

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This copy is for you to read, understand, and keep for your records..

PRE-AUTHORIZATION FOR HEALTH CARE (Client Copy)

CONSENT FOR TREATMENT

By signing this document, I, _____, am indicating that I agree to participate in the following services with The Springs Counseling Group:

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

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4) 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.
5) 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.
6) 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.

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CLIENT SIGNATURE (18 and older) Date

_____ _____

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