

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: _____

Circle The Client's Preferred Phone Number:

Home:(____) _____ Work:(____) _____ Cell:(____) _____

Email: _____ Religion: _____

Employer or School: _____ Full Time ____ Part Time ____

Name and Address of Physician: _____

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

Full name of Primary Insured: _____ Gender: _____

Insurance Company: _____ Insured's Employer: _____

Member ID: _____ Group #: _____

DOB: _____ SSN: _____ (*Insured person's social security number is required*)

Address of Insured: _____ City: _____ Zip: _____

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

CIRCLE THE PREFERRED CONTACT PHONE FOR PRIMARY INSURED:

Home Phone:(____) _____ Work Phone:(____) _____ Cell Phone:(____) _____

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: _____

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

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 LaVonne Dyste, LPC-S:

_____ 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 LaVonne Dyste, LPC-S (hereinafter LD). 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. LD 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 LD and on The Springs Counseling website at www.TheSpringsCounseling.com. I can request a copy of changes at any time at no charge. Any changes that LD 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 (for a child age 17 or younger)
OR SPOUSE

Date

Notice of Financial Responsibility

I understand that this agreement is valid for the duration of time that I am participating in services with LaVonne Dyste, LPC-S (hereinafter LD).

I understand that I will be charged \$160 for an initial individual session, \$160 for each 45-60 minute individual session, \$160 for each 45-60 minute couples session, \$150 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 LD to collect co-payments, co-insurance and deductibles in full. **I am responsible for paying my co-payment at the time of my session.** LD will bill me for co-insurance and deductibles that are due after LD files with my insurance company and receives an explanation of benefits.

If LD is an in-network provider for my insurance company, I am only responsible for the LD contracted rate which may be the same or less than the LD rates for services. If LD is an out-of-network provider, I may be responsible for the difference between what my insurance pays and what LD 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. LD 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. LD does not depend on an outside collection service unless accounts are overdue by 90 days. LD 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 LD 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 LD. I agree that LD 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 LD under the amended agreement. I authorize payment of benefits to LD for any and all services provided by LD.

I understand that if report preparation is requested or required, the time rate charged for our therapy sessions will apply. These services are not usually reimbursed by insurance.

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. This authorization to release information shall be valid through December 31, 2021.

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 \$_____

COURT ACTION/LEGAL FEES:

I understand that this agreement is valid for the duration of time that I am participating in services with LaVonne Dyste, LPC-S (hereinafter LD).

LD will not agree to court appearances or other legal involvement unless we have discussed the matter thoroughly and both agree that such involvement is within LD's range of competence and will not interfere with the treatment relationship. If I become involved in legal proceedings that require LD's participation, I will be expected to pay for LD's time even if LD is called to testify by another party. 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 (\$1500) 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.

1. Preparation time (including submission of records): \$375/hr
2. Phone calls from client and/or attorney consultation: \$375/hr
3. Depositions: \$375/hour
4. Time required in giving testimony: \$375/hour
5. Mileage: \$0.55/mile
6. Time away from office due to depositions or testimony: \$375/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court (not including fees charged by the court for filing a document): \$175
9. The minimum charge for a court appearance: \$1500

A retainer of \$1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional \$250 "express" charge (in addition to the retainer of \$1500). Also, if the case is reset with less than 72 business hours notice, then the client will be charged \$500 (in addition to the retainer of \$1500).

I agree that LD 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 LD under the amended agreement. I authorize payment to LD for any and all services provided by LD.

Signature of client OR Parent of child under 17

Today's Date

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. This notice must be during the Monday to Friday workweek, not over a weekend.

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 210-386-6770.

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 LaVonne Dyste, LPC-S to bill my credit card as listed below for professional fees for myself or _____.

I agree that LaVonne Dyste, LPC-S 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 of \$90 to \$160 - varies by type of session missed)

_____ Appointments I have cancelled with less than 24 hours' notice. (Will be charged at the full fee of \$90 to \$160 - varies by type of session missed)

_____ Telephone consultations (billed in 15 minute increments based on \$150 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

***Please note that HSA/FSA cards CANNOT be accepted.**

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 LaVonne Dyste, LPC-S..

ABOUT THE SPRINGS COUNSELING GROUP AND LAVONNE DYSTE, LPC-S, NCC

Please initial each box:

- I understand that LaVonne Dyste is a Licensed Professional Counselor in the state of Texas
- I understand that LaVonne Dyste 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 LaVonne Dyste about this.
- I understand that LaVonne Dyste 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 LaVonne Dyste to tell someone else in writing or verbally, b) LaVonne Dyste 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 cannot resolve with LaVonne Dyste and I wish to file a formal complaint, I may contact the Texas State 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 LaVonne Dyste.
- I understand that there is a returned check fee of \$25 and that if a returned check is not cleared up in 30 days, LaVonne Dyste 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 each session is \$160.00 and that these fees are for a 45 minute session.
- I understand that LaVonne Dyste 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 LaVonne Dyste 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 LaVonne Dyste dies or becomes unable to continue providing clinical services, Kristin Butler, LPC, will be designated as conservator for my patient records and she 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

This copy is for you to read, understand, sign and leave with LaVonne Dyste.

Date Received and Read

ABOUT THE SPRINGS COUNSELING GROUP AND LAVONNE DYSTE, LPC-S, NCC (Client copy)

Please initial each box:

- I understand that LaVonne Dyste 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

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_____ OTHER _____	

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CLIENT SIGNATURE (18 and older)

Date

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

Date