

Abiding Christian Therapy
12655 Woodforest Blvd. Ste. 700, Houston Texas 77015
Website: abidingchristiantherapyllc.com
Phone: (713)453-2300 Business Cell: (281)536-7561

CLIENT INTAKE FORM

DATE			
CLIENT INFORMATION			
CLIENTS NAME		SSN:	DATE OF BIRTH
GENDER MALE FEMALE	MARITAL STATUS SINGLE MARRIED OTHER		Email:
ADDRESS		CITY/STATE/ZIP	
HOME PHONE	LEAVE MSG? YES NO	CELL PHONE	LEAVE MSG? YES NO
EMERGENCY CONTACT NAME		PHONE NUMER	RELATIONSHIP
EMPLOYMENT	EMPLOYED	FULL TIME STUDENT	PART TIME STUDENT OTHER
If employed, with who and what is the address? _____			
What brings client to therapy? _____			
What/Who has made clients situation better? _____			
What /Who has made clients situation worse? _____			
Have client been under the care of a psychiatrist, psychologist, or counselor? Yes No If yes, please give the name, date, and location of therapy and briefly explain the nature of the problem which required attention: _____			
List any Behavioral Health Conditions and Current Medications: _____			
Primary Care Provider: _____		Phone # _____	
Caseworker Name: _____		Phone # _____	
Probation Officer: _____		Phone # _____	
Please indicate any of the following struggles that pertain to you:			

Anxiety	Depression	Fears/Phobias	Substance Abuse	Suicidal Thoughts
Separation/Divorce	Conduct Problems	Parenting	Marriage	Domestic Violence
Obsessions/Compulsions	Loss/Grief	Eating Disorder	Drug/Alcohol Use	SSI/ Disability
Anger Management	ADHD	Depressed Mood	Insomnia	Social Withdrawal
Work/Stress	Health Problems	Cutting/Self-Mutilation	Hallucinations	Emotional Abuse
Sleep Disturbance	Memory Problems	Physical Abuse	Sexual Abuse	Other...

Client's Name: _____ Responsible Party Signature: _____ Date: _____

PLEASE ANSWER ALL QUESTIONS PRIOR TO INTAKE SESSION

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PREPARATION OF FORMS AND REPORTS

These require chart review and often, discussion with the client. There will be a minimum charge of \$ 25.00 up to a maximum of \$ 200.00 per hour.

APPOINTMENTS, CANCELLATIONS AND NO SHOW FEE

-We realize that on occasion you will not be able to make a scheduled appointment. You can call our office at 713-453-2300 and leave a cancelation message on the voice mail if no one is available.

-However, please remember that this time has been reserved for you alone, so our policy is to charge

\$25.00 for missed appointments or for cancelations without 24-hour advance notice.

No more appointments can be made until the No Show Fee has been paid, there will be no exceptions for this policy.

-Because we have many people who are waiting for appointments, clients who frequently (more than two times) fail or cancel their appointment without a 24-hour notice will not be rescheduled.

-Successful on-going therapy requires a commitment on the part of the client. It is important that you keep appointment if at all possible.

X _____
 CLIENTS NAME

X _____
 RESPONSIBLE PARTY SIGNATURE

 DATE

BILLING INFORMATION

RESPONSIBLE BILLING NAME		RELATIONSHIP TO PATIENT SELF LEGAL GUARDIAN OTHER	
BILLING ADDRESS		CITY/STATE/ZIP	
BILLING PHONE	LEAVE MSG? YES NO	EMAIL ADDRESS	

I clearly understand that I am ultimately responsible for payment to Abiding Christian Therapy for any and all services rendered due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations, as called for in this agreement Abiding Christian Therapy will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, and additional 30% will be assessed to my account to cover the costs of this action Abiding Christian Therapy will not be obligated to provide continuing services to any client who includes Abiding Christian Therapy as a creditor in any bankruptcy filing. My signature below indicates that I fully understand and agree to these terms.

BILLING SIGNATURE (S) (LEGAL GUARDIAN)-Required for services	DATE
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INFORMED CONSENT: My signature below indicates that I am consenting to treatment at Abiding Christian Therapy and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPPA). If I have questions, the information has been explained and/or summarized for me.

SIGNATURE (S) (LEGAL GUARDIAN)-Required for services	DATE
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I AUTHORIZE *Abiding Christian Therapy* to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Abiding Christian Therapy, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify *Abiding Christian Therapy* immediately whenever I have changes in my health condition or health plan coverage in the future.

SIGNATURE (S) (LEGAL GUARDIAN)-Required to bill insurance	DATE
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PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
INSURANCE COMPANY	ID#		INSURANCE COMPANY	ID#	
SUBSCRIBER	DOB	SS#	SUBSCRIBER	DOB	SS#

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CONFIDENTIALITY AND RELEASE OF RECORDS

All information regarding patients is considered strictly confidential and will not be given out to anyone without your written consent. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current TX Dept. of Health maximum allowed. Copies of records are available for a \$ 16.03 processing fee, plus \$1.22 per page for copying.

**** COURT & LEGAL PROCEEDINGS**

Abiding Christian Therapy does NOT provide disability determination or custody studies.

- In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify however factual or in an expert nature, in court or deposition.
- If you are requesting forms for determination of mental illness, disability, court involvement with custody or assessments to be completed, we would be happy to refer you to practitioners in the area who offer this service.
- Should we be called to court by a judge court order or are subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a \$16.03 processing fee, plus \$1.22 per page for copying.
- In the event that it is necessary, (by court order or by subpoena), for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her time.
- Including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) @ the rate of **\$ 500.00 per hour when Mrs. Lezak leaves her front door until she returns**, rounded to the nearest half hour.
- The client further agrees to pay a retainer fee of \$ 2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at Abiding Christian Therapy to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. My informed consent signature shows that this litigation limitation is clearly understood and agreed to.

X _____
Clients Name

X _____
Signature

Date

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CLIENT BILL OF RIGHTS

Abiding Christian Therapy does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client:

- Shall be informed prior to, or at the time of, the intake appointment of the services that are available at Abiding Christian Therapy and of any financial charges that will be the client's responsibility to pay, beyond the coverage of health insurance.
- Can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- Shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his/ her treatment.
- Shall have the freedom to place grievances and recommend changes in policies and services to Abiding Christian Therapy staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Texas have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

Every Client:

- Has the right to be informed of and to refuse to participate in any experimental research.
- May expect courteous treatment and to be free from verbal, physical, or sexual abuse by ACT staff.
- Has the right to a coordinated transfer of care when there will be a change of providers.
- May assert the client's right (s) without retaliation.
- Has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any).

NOTICE OF PRIVACY PRACTICES (HIPPA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Abiding Christian Therapy we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment, for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services.

For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. One of our staff will enter your information into our computer. We may use your information to contact you. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services 1100 Greens Parkway Suite 300 Houston, Texas 77067. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Owner, President, Penny Lezak at 713-453-2300.

X _____ X _____
Clients Name Signature Date