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BILLING/FINANCIAL DATA

CLIENT INFORMATION

Please Print Clearly

***Client** #1 Name: _____ Male Female SS# _____ DOB _____
Please Use Legal Name *Circle One*

***Client** #2 Name: _____ Male Female SS# _____ DOB _____
Please Use Legal Name *Circle One*

***Client** #3 Name: _____ Male Female SS# _____ DOB _____
Please Use Legal Name *Circle One*

***Client** #4 Name: _____ Male Female SS# _____ DOB _____
Please Use Legal Name *Circle One*

Address: _____ City & State: _____ Zip: _____

Preferred Phone #: _____ Email address: _____

Client Employer: _____ Employment Date: _____ Gross Monthly Salary: _____

CLIENT or PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN and SPOUSE INFORMATION

Circle One

***Parent/Guardian:** _____ Male Female SS# _____ DOB _____

Parent/Guardian Employer: _____ Employment Date: _____ Gross Monthly Salary: _____

Circle One

***Spouse/Sig. Other:** _____ Male Female SS# _____ DOB _____

Spouse/SO Employer: _____ Employment Date: _____ Gross Monthly Salary: _____

INSURANCE POLICY INFORMATION

Insurance Company: _____ Phone #: _____

Address: _____ City/State: _____

Policy Holder Name: _____ Male Female Relation to Client: _____

Policy #: _____ Group #: _____

Policy Dates: Start _____ End _____ Annual Deductible: _____ Co-Pay Amt: _____

If Policy Holder Info is DIFFERENT from Parent/Guardian or Client/Spouse Info, PLEASE COMPLETE the following:

Policy Holder SS#: _____ Policy Holder DOB: _____

Policy Holder Mailing Address: _____

Policy Holder Phone Numbers: Home _____ Work _____ Cell _____

FOR OFFICE USE ONLY

Assigned Provider _____ Case Billing Code _____(Pay Status)

Treatment authorized through: _____ Auth#: _____ # of Auth Visits: _____

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CENTERS FOR CHILDREN AND FAMILIES PAPERWORK PROCESSING FEE AGREEMENT

- I understand there may be a fee associated with paperwork processing. I agree to pay this fee, if applicable.
- The amount of this fee, if applicable, will be determined by my pay source. The amount will be disclosed to me prior to my appointment being made.
- I understand that this fee, if applicable, is due in full at the time my appointment is made and prior to my appointment occurring.
- I understand that non-payment of this fee, if applicable, may result in a delay of additional services. Payment may be required for additional services to be provided.

Client or Legal Representative Signature	Relationship	Date
Client or Legal Representative Signature	Relationship	Date

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THERAPYAGREEMENT

Informed Consent

PLEASE READ ALL OF THIS INFORMATION. You will be asked to sign this form indicating you have read and understood what is stated herein. Your signature is consent to enter services at Centers for Children and Families. If you do not understand what is included in this form, please ask the Intake Coordinator or your Therapist for clarification. ***Please do not sign this form until you are satisfied that you understand the contents of this form.***

Assessment and Therapy

As a client at Centers, your first session is for the purpose of assessment. After 2 to 4 sessions, you and your Therapist will develop mutually agreeable treatment goals. If there is a change in the direction of your therapy, new treatment goals will be developed. Your counselor will discuss the duration and frequency of counseling with you.

Broken or Cancelled Appointments

Therapists are not obligated to hold a session when their client is more than 15 minutes late. Appointments must be cancelled 24 hours in advance. If you do not show up for your appointment, if you arrive more than 15 minutes after the time your appointment is scheduled, or if your appointment is not cancelled 24 hours in advance, it is considered a **BREAK.** If you **BREAK** your appointment, **you will be charged a BREAK FEE.**

- The **BREAK FEE** will be your **full copay or self-pay fee.**
- In the event that your insurance does not require a copay, a **$25 BREAK FEE** will be assessed.

Services may cease if you **BREAK** two scheduled sessions.

_____
Initials

Court Documentation

I understand it is my obligation to provide Centers with any updated court documentation relating to the care and custody of my children.

Confidentiality

The staff of Centers for Children and Families is each bound legally and ethically by a very high standard of confidentiality. This means the staff must hold as confidential all information about any client ever seen by a Therapist at Centers. Your Therapist will discuss your case with the Clinical Supervisor, and possibly in a meeting of the Clinical Staff. By signing this form, you will be giving your permission for the professional discussion of your case. There are legal exceptions to this Confidentiality as well, over which the agency has no control, and you need to know about those exceptions: (1) If a client's records are subpoenaed under court order, they must be released to the judge. (2) If a Therapist is subpoenaed under court order to testify in court, that Therapist must comply. (3) If the therapist, in consultation with the Clinical Supervisor, believes there has been, or may be child abuse or neglect, elder abuse or neglect, or abuse or neglect of a disabled individual, that Therapist must report the abuse or neglect to the proper authorities. (4) If the Therapist, addition to the Clinical Supervisor, believes a client may be a danger to him/herself or suicidal, the Therapist must report the possible danger to the next of kin or proper authorities. (5) If the Therapist, in consultation with the Clinical Supervisor, believes a client has made a legitimate threat against the life of another person, this information will be reported to the proper authorities. (6) Unless limited by court order, a parent appointed as a conservator of the child has at all times the right of access to counseling records of the child and to consult with their child's therapist. The parent is only able to access information about their child.

_____ _____
Client or Legal Representative Signature Date

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FEE PAYMENT

Clients are expected to pay the fees they have agreed upon for therapy. Payments are due at the time of service.

Centers for Children and Families adheres to the following policies regarding payment arrangements for unpaid balances on accounts:

1. All balances must be paid off within a six-month time frame.
2. An amount equal to or greater than one-half (1/2) of total balance owed will be payable upon initiation of payment arrangements.
3. The remaining balance will be divided into no more than 6 equal payment amounts in order to pay off the balance within the six-month time frame mentioned above.
4. All payments are due on the first of the month, regardless of appointment date or time. **It is the client's responsibility to mail or bring payment if this does not fall on an appointment time or date.**
5. All payments are **IN ADDITION TO** client's normal co-pay amount.
6. Amounts paid will be applied first to outstanding balance and then to current co-pay amount.
7. Account must be kept current for payment plan to remain in effect. Payment plan will be terminated and full amount becomes due and payable if payment plan falls into default.
8. If at any time a client becomes 2 payments behind on either co-pays, self pay fees, or a payment arrangement plan, they will not be rescheduled until payments are brought current.

_____
Initials

IF FOR ANY REASON YOUR INSURANCE COMPANY HAS NOT PAID YOUR CLAIM WITHIN 45 DAYS OF FILING, THE BALANCE WILL AUTOMATICALLY BE TRANSFERRED TO YOUR ACCOUNT AND BECOME YOUR RESPONSIBILITY.

Grievance Procedure

The Agency has a procedure to address any concerns about the professional services that are being rendered to you by your Therapist so that you may continue to receive professional services of the highest quality. A copy of the agency's policy outlining this procedure will be provided to you.

CLIENT AGREEMENT STATEMENT

"I have read (or have had read to me) and understood, the preceding information, and I agree to the terms of this agreement."

Client or Legal Representative Signature	Relationship	Date
Client or Legal Representative Signature	Relationship	Date

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Setting Your Fee

The Agency cost per counseling session is **$120.00**.

If you have **Medicaid/Medicaid affiliate**, it is necessary to bring the Medicaid/Medicaid affiliate card with you to **each session**, as a copy of the card needs to be made and filed.

CENTERS DOES NOT RETROACTIVELY BILL NOR FILE SECONDARY INSURANCE.

Insurance verification is not a guarantee of benefits and certain terms, limitations, and co-pays may apply. Your initial copay amount may change upon receipt of an EOB due to these factors. Determination will be made upon receipt of first EOB by Centers and any unpaid balance will be your responsibility.

If you have INSURANCE that covers the services provided by this Agency, Centers will file a claim with your insurance company.

If you have INSURANCE that covers the services provided by this Agency, your portion of the fee is your insurance Co-pay/Co-Insurance (per session) as determined by your insurance company. Final determination of this fee is dependent upon information received on an EOB.

If it is determined that your INSURANCE DEDUCTIBLE has NOT been met, you are responsible for a **$50 fee per session**. Any unpaid difference between your copay and the $50 fee will be your responsibility. Your insurance will be filed accordingly.

SELF-PAY fees are determined by Centers and based upon your household's total (gross) income.

If you have INSURANCE that DOES **NOT** COVER the services provided by the agency, you will be required to pay your assessed **Self-Pay fee** per session.

If you DO **NOT** HAVE INSURANCE, you will be required to pay your assessed **Self-Pay fee** per session.

_____ _____

Client or Legal Representative Signature Date

ASSESSED THERAPY FEE

INSURANCE, CHIPS, MEDICAID, OR SELF PAY (no Insurance Coverage)

THERE IS NO FEE ASSESSED FOR THE AUTHORIZED NUMBER OF EAP SESSIONS.

Personal Fee per session $_____

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CONSENT FOR TREATMENT

(By Parent or Legal Guardian)

I, _____, hereby give my consent and authorize Centers for Children and Families, Inc. to treat _____.

I have the legal authority to authorize and consent to such treatment, because (initial one):

_____ I am the PARENT of the above named CHILD, and no court has appointed another person managing conservator or guardian of my child;

_____ I am the COURT-APPOINTED MANAGING CONSERVATOR or LEGAL GUARDIAN of the above named CHILD;

_____ I am the COURT-APPOINTED GUARDIAN of the above named ADULT;

_____ I have WRITTEN AUTHORIZATION to consent to psychological care for the above named minor CHILD or ADULT from a person authorized by law to consent to such care;

_____ OTHER (Please explain in the space provided): _____

_____

I understand that information concerning the treatment of the above named person will be divulged only to me; those others who have the legal right to receive such information, to include the other parent if the client is under 18 years old (provided that person's rights have not been restricted by the law regarding such information); OR those person(s) I have expressly authorized to receive such information by signing a "Consent to Release Information" form.

The original of this Consent for Treatment Form is a part of normal agency documentation, and shall be kept on file in the records of Centers for Children and Families, Inc.

I certify that I have read and fully understand the above consent, that the explanations referred to were made, and that all blanks or statements requiring insertion or completion were filled in before I signed.

_____ _____

Authorized Signature (verified by identification) Date

DEAR PARENT(S):

CENTERS FOR CHILDREN AND FAMILIES wants to assure that all children that visit or receive services at our agency remain safe in the process. To that end,

1. Please accompany your children into the office; do not drop children off outside for appointments. **Children 12 and under and/or older youth needing specialized attention must be accompanied by an adult into and out of our offices for all appointments.**
2. Children 12 and under and/or older youth needing specialized attention must have a parent/guardian present at Centers throughout their ENTIRE APPIONTMENT TIME. When in the waiting room, they must be supervised by a responsible adult and/or family member at all times. The therapist reserves the right to discontinue services with families that are unable adhere to this policy.

Our staff will be monitoring these issues closely. We are asking for your cooperation in following each of the above requests.

All parents/guardians are required to sign this form and discuss the need for adhering to these guidelines with their children. If you have any questions, please do not hesitate to ask.

Thank you,
Marc McQueen
Director of Clinical Services

I, _____, agree to the above guidelines.
Parent/Guardian Signature

_____
Date

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STATEMENT OF CONFIDENTIALITY FOR CLIENTS

The identity for CENTERS' clients, communication with clients, and facility records, which may directly identify a client, former client, or potential client, are to remain confidential and are protected by Texas Laws relating to Mental Health Mental Retardation (Article 5561H, see 2a and 2b).

As a client at the office of CENTERS FOR CHILDREN AND FAMILIES, I understand that I must comply with CENTERS' policy regarding confidentiality. I also understand that this applies to all visits made at CENTERS from this date forward.

I understand that I may discuss any questions I have regarding this policy with the Intake Coordinator or Director of Clinical Services.

I agree to abide by the CENTERS confidentiality policy and further understand that failure to comply could result not only in being requested to leave the facility but could also result in other appropriate disciplinary and/or legal action being initiated by CENTERS.

_____ _____
SIGNATURE DATE

I give Centers' staff permission to contact _____
NAME
at _____ in case of a medical or mental health emergency.
PHONE NUMBER (S)

This consent also gives permission _____
This consent does not give permission _____
That should my appointment need to be canceled or rescheduled the above named person may be contacted, in the event I am unable to be reached.

_____ _____
SIGNATURE DATE

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HOUSEHOLD MEMBERS

Complete for ALL Household Members (include roommates, grandparents, etc. living in the same house as the client)

Name	Social Security #	Gender	Birthdate	Race	Relationship to Client
(client name here)					

AUTHORIZATION TO RELEASE INFORMATION

I/We, _____, hereby authorize CENTERS for Children and Families, Inc. to release
(Client or legal Representative)

their records and/or information concerning _____
(Clients Name[s])

to _____.
(Insurance Company, EAP, CHIPS, or Medicaid)

I/We authorize Centers for Children and Families to release any mental health, substance abuse, assessment, or medical treatment information necessary to effect treatment or claim payment. I/We understand that confidential mental health information will not be released by Centers for Children and Families to my employer, family, or others not identified without my consent. I further authorize payment to Centers for Children and Families.

_____ _____ _____
Client or Legal Representative | Relationship to Client | Date

_____ _____ _____
Client or Legal Representative | Relationship to Client | Date

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CONSENT TO USE AND DISCLOSE YOUR CLINICAL INFORMATION

This form is an agreement between you, _____, and CENTERS FOR CHILDREN AND FAMILIES. In addition to yourself, this agreement may include your child, a relative or another person designated in the following space: _____.

When we treat you, we will be collecting what the law refers to as Protected Health Information (PHI). We need to use this information to determine the best course of treatment. We may also share this information with others who are involved in your treatment or need the information in order to arrange for payment of you treatment.

By signing this form, you are agreeing to let us use your information and send it to others. The Notice of Privacy Practices explains in more detail your rights and how information is used and shared. Please read our Privacy Practices before signing this form.

IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO OUR PRIVACY PRACTICE, WE WILL NOT BE ABLE TO TREAT YOU.

In the future, we may change how we use and disclose information. If our Privacy Practices do change, you may receive an updated copy from our office or request on from our Privacy Officer.

If you are concerned about your personal information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative functions. Any such request will need to be in writing. We will try to respect all requests, but are not required to agree to every limitation.

After signing this consent, you have the right to revoke the consent through written request. Any information shared before that time cannot be taken back.

_____ _____
Signature of client or representative Date

_____ _____
Printed Name Relationship to Client

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Centers for Children and Families' Counseling program relies up on grant money in addition to other sources of revenue in order to provide services. Please take a moment to complete the following demographic information that is required for us to meet the requirements of grant proposals.

Race: ___ Asian; ___ African-American; ___ Native American; ___ Caucasian; ___ Hispanic
___ Pacific Islander; ___ other (Please list) _____

Gender: ___ Male ___ Female

Age: ___0-6yrs; ___7-13yrs; ___14-17yrs; ____18-30yrs; ____31-49yrs; ____50-64yrs;
____65-74yrs; ____75-84yrs; ____85+yrs

Household Annual Income: ___ $0- 20,000; ___ $21,000 - 25,000; ___ $26 - 30,000; ___ $31-40,000;
___ $41-50,000; ___ $51-60,000; ___ $61-70,000; ___$71-80,000; ___$81,000 +

Household Size: ____1; ____2; ____3; ____4; ____5; ____6; ____7; ____8+

County of Residence: ____Midland County; ____Ector County; ____other (please list) _____

Referral Source: ____ Voluntary Participation; ____ Court Ordered Participation;
____ Attorney Referral; ____ CPS Referral; ____ Parole Office;
____ Other (Please list) _____

Reason Seeking Services: _____

United Way
Program Provider

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CLIENT GRIEVANCE POLICY

If a client becomes dissatisfied with the services received from Centers for Children and Families, the client has the right to appeal any grievance to their Therapist, then to the Clinical Director, and finally to the CEO to seek correction of the situation that led to the client's dissatisfaction. The CEO has the option of presenting the client's concern to the agency's Board of Directors. During the initial contact with the client, the client should be informed that his/her grievance rights also apply to the client or client's legal representative.

The client shall be assured at every level of the grievance stage, that their appeal shall not prejudice the client's receipt of agency services. The CEO and, if necessary, the Board Chair, shall assure that no prejudice occurs.

If the client appeals to the CEO without first appealing to the Therapist and/or Clinical Director, the client may be referred back to the Therapist and/or Clinical Director.

Initial grievance to the Therapist and Clinical Director may be done verbally or in writing. Great effort will be taken to mutually resolve client grievances on this level and in a timely manner. Centers' hope is that client concerns do not lead to disruption in services. The request for appeal to the CEO must be in writing, with such request including a brief statement of the grievance. This may include a statement of the client's intention to bring a friend or other representative to the appeal meeting. Whenever possible, such appeals shall be handled by the appropriate agency professional within ten working days of such request. A copy of the Grievance Procedure will be given/mailed to the appropriate agency representative.

Those individuals cited in the client's grievance shall be informed of such grievance and the client shall be informed of any action taken in response to the grievance. A record of the grievance and outcome shall be entered into the client's case record by the counselor and reviewed by the Clinical Director and CEO. Every effort shall be made by the agency to utilize such grievance to improve agency services.

Anyone wishing to file a complaint with the Licensing Board against a Licensed Professional Counselor may write to:

Complaints Management and Investigation Section
P.O. Box 141369
Austin, Texas 78714-1369
or call: 1-800-942-5540

Complaint forms may also be obtained through the Texas Department of State Health Services website.

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Notice of Privacy Practices - Brief Version

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. What you are reading is a shorter version of the full, legally, required Notice of Privacy Practices (NNP). Please refer to our longer, complete version for more information. However, we are unable to cover each and every situation that may arise, so please talk with our privacy officer regarding any questions that arise.

We will use your clinical information, which we will get from you or from others, mainly to provide you with TREATMENT, to arrange PAYMENT for our services, and for other business activities, which are called in the law, health care OPERATIONS. After you read this NPP, we will ask you to sign a CONSENT FORM to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If you or we want to use or disclose (send, share, or release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization specifically for that purpose.

Of course, we will keep your clinical information private, but there may be occasions when the law requires us to use or share this information. For example:

1. When there is a serious threat to your safety or the health and safety to another individual/public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Certain lawsuits and legal/court proceedings.
3. If a law enforcement official requires the information.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these, which do not happen very often. They are described in the longer version of the NPP.

Your rights regarding your clinical information.

1. You can ask us to communicate with you about your clinical and related issues in a particular way or in a certain manner that is more private to you. For example, you may ask us to call you at home rather than work regarding your appointment schedule.
2. You have the right to ask that we limit the information shared to others involved in the continuum or the payment of your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is deemed necessary to treat you.
3. You have the right to look at the clinical information we have about you including your clinical and billing records. Please contact your provider or Privacy Officer to arrange the review of any records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your clinical information. You have to make this request in writing and send it to the Privacy Officer. The reasons for requesting these changes must be clearly defined.
5. You have the right to a copy of this notice. If we change the NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the care provided to you in any way.

If you have any questions regarding this notice or our privacy policies, please contact our CEO, Kristi Edwards. She may be reached by phone at 432-570-1084 or by email at kedwards@centerstx.org.

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Centers' Grievance Policy and Notice of Privacy Practices are available for my information.

Client or Legal Representative Signature

Date

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INITIAL CLIENT SHORT FORM QUESTIONNAIRE

I have previously been involved in the counseling process	Y	N	Unknown
I have a general understanding of the counseling process	Y	N	Unknown
I am initiating counseling on my own	Y	N	Unknown
I am initiating counseling at the request of a friend or family member	Y	N	Unknown
I have been diagnosed with a Serious Mental Illness	Y	N	Unknown
I expect positive outcomes as a result of attending counseling sessions	Y	N	Unknown

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Before you can be assigned to a therapist, please return the following to the office via mail, fax, or in person.

- Medicaid/ CHIPS card
- Court papers indicating you have custody or managing conservatorship of the minor children being treated
- Income verification (one of the following: recent check stubs for all working members of the household, W-2 forms, income tax return, letter of indigency, bank statement showing disability deposit amount)
- Copy, front and back, of insurance card
- Other:_____

Your prompt attention to these matters will help expedite your assignment to a therapist.

Thank you.

Centers for Children and Families
3701 Andrews Hwy
Midland, TX 79703
Office: (432) 570-1084
Fax: (432) 570-4069