**Registration Form**

Please print and bring completed form to your first appointment-Thank You

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F Age:\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Primary Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave message? Y/N

Primary Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? Y/N

Emergency Contact Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_

Will we be filing under insurance plan for services rendered today? Yes or No (circle one)

If Yes, please complete insurance information below:

PLEASE NOTE: We will verify your benefits as a courtesy. Verification of your benefits does NOT guarantee payment by your insurance company. This means ultimately you are responsible for payment of your session fees if the claim comes back denied for any reason.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Insurance Plan Name  or Self Pay | ID Number | Group Number | Type of Plan (HMO/PPO) | Texas or out-of-state plan? | Deductible met to date? | Deductible amount remaining? | Co-pay Amount? |
| Secondary plan: |  |  |  |  |  |  |  |

\*We do not accept Medicare, Medicaid, or EAP plans.

Primary Insured Name (name of person who carries the insurance): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the primary insured relationship to the client? (circle one) Self Spouse Parent Legal Guardian

Primary Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_ Primary Insured SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured Employer\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insured Address (if different from client): \_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

**Counseling Fees and Services**

Initial Evaluation $125.00 (Masters Level Therapist)

Initial Evaluation $135.00 (Dr. Jon Shepard, Licensed Psychologist)

Crisis Management, additional $100.00

Written Reports $150.00 (per hour)

Records Request $35.00 minimum

No-Show Fee $125.00/$135.00 Dr. Jon Shepard

Late Cancellation Fee $62.50

**Insurance**

Verification of insurance benefits by LWC does not guarantee payment of claims once they are processed by your insurance company. Prior to your appointment, it is important you call your insurance company to review your insurance benefits and financial responsibility for mental health benefits as plans may vary. You are responsible for payment in full for any remaining balance on your account as a result of an unpaid or denied claim. We are not able to file with secondary insurance plans and do not accept EAP plans.

**Cancellation & No Show Policy**

We have a strict cancellation policy in place**. Please give us a full 24-hour advance notice** if you need to cancel or reschedule your appointment for any reason. This appointment time is scheduled just for you and if you are unable to attend session without providing a full 24 hour notice for any reason you will be charged a late cancel fee in the amount of $62.50. A ‘no-show’ fee is the full cost of the session $125.00 Master’s Level Clinician or $135.00 for Dr. Jon Shepard.Please Note: Youare responsible for calling to cancel or reschedule your appointment between normal business hours M-F 8:30 AM to 6:00 PM (excluding weekends and holidays). **Please note if a cancellation is made after 6:00 PM or on a weekend or Holiday** prior to your scheduled appointment day it is considered a late cancel. There are no exceptions to this policy.

**Telephone Procedures and Emergencies**

Administration Office Hours M-F 8:30 AM – 6:00 PM. Please call our main office phone (817) 238-0106 to contact a member of our support team. If you are in need of a follow-up consultation with your counselor for any reason please call to schedule an appointment, as counselors typically do not consult over the phone. If you have an urgent or life threatening emergency, please call 911 or go to your nearest emergency room.

**Nature of Counseling**

All of the counselors at LWC may have different styles, techniques and personalities but we all have one mission; to provide you with professional, qualified counseling services for you and your family in a comfortable setting, facilitate personal growth and improve your overall well-being. You as the client, are freely choosing to enter into treatment and may choose to end treatment at any time. Your relationship with your counselor is a professional and therapeutic one only. We do not participate in social or financial relationships or engage in social media networks with our clients. ***If, for whatever reason, you feel your counselor is just not a good ‘fit’ for you after an initial consultation you may request that you continue your work with another one of our professionals.***

**Client Records**

All client records are maintained according to state guidelines and are considered the possession of Lake Worth Counseling, PLLC. A request for a release of your client records or notes concerning a minor child must be submitted by written request. A records request fee is a min. of **$35.00.**

**Grievances**

We encourage you to discuss any problems you may have directly with your counselor or our office administrator. We will work with you respectfully to resolve any issue you bring to our attention in order to reach a satisfactory agreement. You may submit your concerns to info@lwc.care or call Susan Schlosser

Shepard directly at cell (682)556-9096. If you are not satisfied with the response you receive, you may submit your grievance to the Texas State Board. To report a rules violation by a licensee, contact the appropriate Board:Texas State Board of Examiners of Licensed Professional Counselors; Texas State Board of Examiners of Marriage and Family Therapists; Texas State Board of Social Work Examiners at the following common address:*P.O. Box 141369, Austin, TX 78714-1369 (1-800-942-5540).*

**Acknowledgement of Review of Notice of Privacy Practices**

Clients have a right to review Notice of Privacy Practices concerning protected health information prior to signing this document. The Notice of Privacy Practices is also provided on our website www.LWC.Care

**Limits of Confidentiality**

Discussions between a therapist and a client are confidential. No information will be released without the client’s written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: court subpoena, child abuse, abuse of the elderly or disabled, sexual exploitation, criminal prosecutions, child custody case, situations where the therapist has the duty to disclose, or where, in the therapist’s judgment it is necessary to warn or disclose. If you have any questions regarding confidentiality you should bring them to the attention of the therapist to discuss this matter further. By signing this consent form the client is giving consent to the undersigned therapist to share confidential information with all persons mandated by law and the insurance carrier and billing companies responsible for providing mental health care services and payment for those services, and also releasing and holding harmless the therapist from any departure from right of confidentiality that may result. A counselor may converse with other counselors in the LWC group practice for consult in order to provide the best possible treatment for a client.

**Court Related Issues/Legal Matters & Fees**

Although it is our goal to protect the confidentiality of confidential records, there may be times when disclosure or your records or testimony will be compelled by law. If subpoenaed by a judge LWC may be obligated to provide the requested information, whether or not the information is favorable to the undersigned. Should you involve your counselor in a legal matter such as custody issues, a retainer fee of $1500.00 is required up front and LWC must be notified in advance of intent to subpoena.

**Appointment Reminders** LWC sends out an automated text and email reminder with your permission to the email address we have on file for you approximately 24 hours in advance, however this is a courtesy service and you are ultimately responsible for attending your scheduled appointment.

**Assignment of Insurance Benefits**

By signing below, the client authorizes all insurance payments to be made to the designated provider. This order does not relieve the client of obligation to pay such bills if not paid by the insurance company for any reason. It is the patient’s responsibility to ultimately verify their behavioral health benefits and any cost that may occur. LWC may provide benefit verification as a courtesy only and must have on file the correct insurance information in order to file claims with the insurance company. Denied claims will then become the patient’s responsibility.

***Please Note: If you elect to use your behavioral health plan please be mindful that a behavioral health diagnosis must be provided by your counselor for counseling sessions to be covered.*** *This diagnosis may become a permanent part of your medical records. Please discuss any concerns you may have about a diagnosis with your counselor. If a medical doctor has already assigned a diagnosis and you are receiving treatment for such (adjustment disorder, anxiety, depression…) we will use the same code if applicable. It shall be determined by your mental health provider the appropriate diagnosis and procedure code that shall be assigned to you and billed to your insurance company.* If you choose to not use your behavior health benefits for this reason please let us know you will be a self-pay client and that you elect not to have a diagnosis filed for privacy reasons.

**CANCELATION POLICY CC AUTHORIZATION FORM**

*LWC request this form be updated for your patient records as of 05/15/2017*

In order for us to provide the best therapy for all clients we require a full 24-hour notice if you are unable to keep your scheduled appointment. Your notification allows us to schedule another client whom may be waiting to be seen. A late cancelation (less than 24-hour notice) will incur the following fee:

**Late Cancel Fee - $62.50**

**No Show Fee – Full Session Fee**

* I understand that insurance does not cover late cancellation charges.
* I understand I must call during our regular business hours M-F 9:00 AM – 6:00 PM (excluding holidays and weekends) to cancel or reschedule my appointment. It is considered a Late Cancel if I call after normal business hours, a weekend or a holiday prior to my scheduled appointment.

**Credit Card Authorization:** My credit card information I supply is true and complete, (ii) charges incurred by me will be honored by my credit card company or financial institution, and (iii) I will pay the charges incurred by me at the posted prices, including any applicable late cancel fees or past due balances on my account. My credit card shall remain on file to reserve my upcoming appointments and provide guarantee of payment. I understand my credit card will not be charged without my permission unless I simply do not show up for my appointment, I incur a Late Cancel Fee or have an outstanding balance due on my account.

Cardholder Name(as it appears on card) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MC/Visa/Amex Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3 digit security code \_\_\_\_\_ Exp.Date\_\_\_\_\_

Billing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_

Authorized Cardholder Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

***I have read and understand the LWC Late Cancel Policy and my signature above authorizes payment for all services rendered at Lake Worth Counseling, 4516 Boat Club Road, Ste 106, Fort Worth, Texas 76135.*** *If unable to provide credit card on file, client may leave a deposit of $62.50 which shall be refunded 30 days after termination of counseling services and account in good standing.*

**Signed Consent for Treatment at Lake Worth Counseling**

I have read and understood the Fee Policy, HIPPA & Privacy Practices, Limits to Confidentiality, Verification and Assignment of Insurance Benefits, Legal Matters & Fees and Policy and Procedures including the Late Cancellation Policy and Credit Card Authorization information. My signature below indicates that I give full and informed consent for me and/or my child(ren) to receive counseling services at LWC and to the terms set forth in this agreement (version 05/15//2017).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If child client(s) please complete:

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_Parent Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Parent Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lake Worth Counseling Policy and Procedures**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please read and initial each line below - Thank You*

**\_\_\_\_\_\_\_\_ Counseling Fees & Scheduling**: A therapeutic hour is 45-50 minutes in order to allow for a brief summary and client scheduling at the end of the hour. Counseling fee per session is $125.00. Psychological assessments, counseling, and testing performed by Dr. Jon Shepard is $135.00. Payment by cash or credit card only.

**\_\_\_\_\_\_\_\_ Cancellation & No Show Policy:** Please call at least **24 hours-notice** if you need to cancel or reschedule an appointment for any reason otherwise you will be charged$62.50 to be applied to your cc on file. A ‘no-show’ appointment will result in the full cost of the session $125.00 for M.S Level Clinician or $135.00 for Dr. Jon Shepard. You are responsible for calling to cancel or reschedule your appointment between normal business hours M-F 8:30 AM to 6:00 PM (excluding weekends and holidays). Please note if a cancellation is made after 6:00 PM or on a weekend or holiday prior to your scheduled appointment day it is considered a ‘late cancel’ and you will be charged a fee.

**\_\_\_\_\_\_\_\_ Emergencies:** Phone calls are returned during regular business hours M-F, 8:30 AM 6:00 PM. However, if you have an urgent or life threatening emergency please call 911 or go to your nearest emergency room. We do not have an after-hours answering service available and are available during normal business hours for scheduling appointments.

**\_\_\_\_\_\_\_\_ Client Records:** Please complete a *LWC Records Request Form* for release of your client records. A min. fee of $35.00 will be charged to process your records. We must have a written consent form on file to release your records to you or another party. **We do not process disability request issued by the state**. If you wish to request a professional written report for disability, legal, work or any other purpose we are happy to provide a written assessment report for a fee.

**\_\_\_\_\_\_\_\_ Notice of Privacy Practices:** We are required to provide you with a copy of our Notice of Privacy Practices which is available on our website at www.LWC.Care and at check-in. This notice states how we may use and/or disclose your health information.

**\_\_\_\_\_\_\_\_ Insurance:** I understand that LWC will file with my primary insurance plan however if the insurance claim is denied for any reason, I agree to pay for the services rendered to me. I understand an insurance plan is a contract between the insured party and the insurance company and ultimately it is up to the client to verify behavioral health coverage or to contact the insurance company directly if a claim has been denied or you have questions about your co-pay or deductible. **If my deductible has not been met to date I am responsible for the $125.00 session fee until my deductible has been met.** We do not accept Medicare, EAP plans or file with secondary insurance plans including Medicare or Medicaid.

**\_\_\_\_\_\_\_\_ Appointment Reminders:** LWC sends an automated text/email reminder to the phone and email address we have on file for the client as a courtesy, however you are ultimately responsible for attending your scheduled appointment time. Your therapist may also provide a written appointment reminder.

**\_\_\_\_\_\_\_\_ Credit Card Information on File**

We require all clients to have a signed credit card authorization on file before beginning counseling in order to secure services. You agree to be the guarantor of all appointments scheduled with Lake Worth Counseling, including missed appointment fees, co-pay amounts, deductibles or denied insurance claims. If you have a balance 30 days past due, your cc account on file will be charged the outstanding debt.

**\_\_\_\_\_\_\_\_ Scheduled Appointments:** LWC understands from time-to-time an appointment may need to be cancelled or rescheduled, however I understand as a client I must attend regularly scheduled appointments in order to best achieve my therapeutic goals. If I have three consecutive cancelled appointments, I will be unable to schedule an appt. with LWC and given an outside referral source.

**\_\_\_\_\_\_\_\_ Legal Matters & Fees:** Should the client become involved with any legal matters involving testimony or subpoena to Lake Worth Counseling I must notify my counselor immediately and arrange payment with LWC including an initial retainer fee of $1500 to secure my counselor’s professional services and advice.

**INSURANCE DISCLAIMER**

Updated 05/15/2017

**Insurance Patients – You may owe more than what is collected today.**

Lake Worth Counseling will do our best to determine your payment amount by obtaining an estimate of your insurance benefits. We will collect the “estimated portion” today and file the claim with your insurance company. Today’s estimate is not a guarantee of coverage or the amount your insurance company will pay. If your insurance company indicates you owe more than what you paid at the time of service or if a **service is not covered by your insurance company**, Lake Worth Counseling will bill you for the remaining balance.

If we are unable to obtain an estimate for your insurance benefits or you have a deductible and the deductible is not met, you will be required to the pay the full session rate of $125.00 Masters Level Counselor/$135.00 Dr. Jon Shepard. **Please Note: Lake Worth Counseling shall charge their standard session rate prior to patient’s deductible being met (which may be different from the contracted insurance rate applied to your EOB and is typically a lesser amount).** If you have met your deductible after the claim is filed and are eligible to receive a refund, Lake Worth Counseling will promptly send you a refund check.

\_\_\_\_\_\_\_\_(Client Initials) I have read the above disclaimer and understand I am responsible for services rendered to me and the appropriate fees, including sessions fee, co-pay, co-insurance, deductible amounts or any outstanding balance due on my account resulting from insurance denied or unpaid claims.