New Client - Minor

Our mission is to help you achieve emotional balance through individual, family, & group therapy

Client Name: _____ Birthdate: ___/___/___ Age: _____

Guradian Name: _____ Gender: _____ Grade: _____

Street Address: _____

City: _____ State: _____ Zip: _____

School: _____ District _____

Contact Information

Cell: _____ Secondary Phone: _____ Secondary _____

Email: _____ Phone owner

Preferred Contact Method: Cell: ____ Secondary Phone: ____ Email: ____

I give permission for my therapist to contact me using non-secure methods regarding reminders, scheduling, or other relevant matters, and I understand the risks involved: Please circle Yes or No -→ Yes No

Can a voice mail be left on the provided phone numbers: Yes No

Can a text message be sent on the provided phone numbers: Yes No

Supportive Person Name: _____ Will this person join therapy sessions? _____

I, being the above named client, give permission for _____ to make, cancel or reschedule appointments on my behalf. I understand that any appointments made in my name are subject to Hope & Harmony's cancellation and no show policy.

Client Health Information

List any Chronic Health condition(s): _____

Current Medications/Dosage _____

Allergies: _____

Current Behavioral Health Diagnosis (if applicable): _____

Reasons for beginning therapy at Hope & Harmony Therapy: _____

How did you hear about Hope & Harmony Therapy? _____

Service Type	Service Description	Service Fee
Standard Billable Rate	One Session (45 minutes)	$120.00
Group/Workshop Rate	Time Varies By Group; Generally 90 Minutes	Varies By Group
Phone/Email Rate	Over 10 minutes billed at	$1.50/minute
Appointment No Show Fee	Cancellation less than 24 hours or No Show	$60.00
Letters For Court/Work/School	72 hrs notice must be given. Does Not Include School/Work Excuse	$35.00/letter
Request/Copy Of Records	$50.00 for first 25 pages	$1.00/page thereafter

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Please read and review the following information carefully:

Hope & Harmony Therapy provides therapy for individual adult and children, couples, and families. Occasionally, Hope & Harmony Therapy offers adult and teen groups and workshops. For questions about groups or workshops please ask your therapist. *Hope & Harmony Therapy does not provide medication of any kind.*

~~What to Expect from Therapy: We work from a systemic perspective, which means we view clients in the context of their immediate family and larger social system as being important resources in solving life's problems. Goals for therapy are always established through collaboration with the client(s). I work from a structural/solution-focused orientation, which means that I assist couples and families in organizing their relationships so that resources can be brought to bear on the problems being presented. Techniques that are often employed are psycho-education, modeling and role playing more positive and effective communication skills, along with between session assignments and goals created by the client(s) and their therapist.

What I Expect From Clients: Clients must make their own decisions regarding such things as educational changes, changes in marital status such as separation, divorce, reconciliation, parenting and co-parenting, custody and visitation. **I am here to help you think through the possibilities and consequences of decisions, but I am not going to make a specific decision for you.**

~~Privileged Communication: I am required to abide by the professional practice standards for a licensee in the State of Texas. I do not disclose client confidences and information to any third party, except for materials shared during supervision, without a client's written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the proper authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled adult abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm. Certain types of litigation (such as child custody suits) may lead to court-ordered release of information without your consent. If a complaint is made against the therapist license, that therapist may use case information to defend this complaint. When working with couples, families, and/or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, I will not release any information about either or both spouses that have been seen for marital therapy to an attorney without signed authorizations from both spouses. Hope & Harmony Therapy and its staff make every effort to comply with HIPAA privacy laws and the policy information is available on the website: www.hopeandharmonytherapy.com. A copy will be supplied upon request.

Electronic Communication: Electronic communication, via email and text, between you and your therapist may not be secure. By signing this document, you are acknowledging that you realize that email and text communication does not provide a completely secure means of communication. While your therapist will take reasonable efforts to protect your confidentiality, there is some risk that any protected health information contained in email or text may be disclosed to or intercepted by unauthorized third parties. You also have the right to terminate this agreement at any time. Use of more secure communications, such as phone or fax, are always an alternative that are available to you if you elect to not give consent to the following forms of communication

After-Hours Emergencies: When the office staff is unavailable to answer calls or after normal office hours, you may leave a message on Hope & Harmony Therapy's main voicemail and your call will be returned as soon as possible. In an emergency situation or when an immediate response is necessary, please call 911 or go to your nearest emergency room.

Records and Court: Client files and records are the property of Hope & Harmony Therapy. Client files and records will be maintained in accordance with current State and Federal laws and will consider the end date of a treatment episode as the basis for file destruction. Hope & Harmony Therapy **does not provide Custody Evaluations or Expert Witness court testimony.** If I am asked to produce a copy of client records, there is a minimum charge of **$50.00 for up to 25 pages** and a cost of **$1.00 per page thereafter**. Copy fees are due prior to release of the record. If Hope & Harmony Therapy is subpoenaed by a judge to testify, the minimum charge is **$750.00**, due prior to the court date, for any time up to **three hours** (this includes preparation time, travel, and testifying), additional time is charged at **$250.00 per hour**.

Potential Risks and Benefits of Therapy:

- Making changes through the therapy process may produce other unforeseen changes in a person's life.
- A risk in the therapy process could be feeling worse before feeling better.
- Changes in relationship patterns that may result from therapy may produce unpredicted and/or possibly adverse responses from other people in the client's social system.
- A result of therapy may be a realization on the part of the client that there are issues that may not have surfaced prior to the onset of the therapeutic relationship.
- Couple or family conflicts may initially intensify as feelings are expressed. Individuals in couple or family therapy may find that partners or family members are not willing to change.

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Please read following statements carefully and initial where indicated:

Appointment Reservations: The therapy room is reserved specifically for you. Appointments are usually scheduled one time per week for approximately 45 minutes, with the initial session devoted to gathering all necessary information. The entire therapy process may take an average of eight to ten sessions.

Initial: I understand that, if applicable, I will be charged a fee of **$60.00** for the following reasons**:**

- If I do not show up for my appointment and have not given proper cancellation notice
- If I do not cancel my appointment 24 hours before my scheduled session time
- If I am more than 15 minutes late and the therapist has already left the office

_____ I understand that it is acceptable to leave a voicemail or text at 281.900.9575 or to send an email to info@hopeandharmonytherapy.com for a cancellation notice in order to avoid a no show fee. If I am running late, I can make a courtesy call to Hope & Harmony Therapy.

_____ I understand that if I reschedule, cancel, or no show my appointment 3 times in a row that I must pre-pay at the current private pay rate prior to making any future appointments. No refunds will be given if pre-pay appointments are cancelled or missed.

_____ I understand that all fees due are to be paid at the time services are rendered. Payment may be by cash, check, select credit cards and flexible spending/health savings account credit cards. Advanced payments are to be used within 2 weeks of payment date. No refunds on services or advanced payments, including clients on a prepay plan.

_____ I understand that a **$30.00** fee will be charged at or before the next session for returned checks or declined/invalid credit cards in addition to session fees due. If fee is unable to be charged, an invoice will be mailed to the address listed on page 1 of this form.

_____ I understand that I am responsible for any additional fees incurred by Hope & Harmony Therapy, for any disputed credit card charges. Prior to disputing credit card charges from me, please discuss the charges with me in order to avoid these fees.

_____ I understand that my client file will be closed after a 30 day lapse in services. When I return I understand my fee will be at the current, standard rate or private pay discount rate.

_____ I understand that this form is valid unless I cancel the authorization through written notice to Hope & Harmony Therapy

_____ I understand that my counselor may "follow up" with me after counseling has ended. 1 month, 3 Month, or 6 Month follow up calls may be made to check in with clients and see if gains made in counseling have been maintained. In addition, someone from our team might call you to ask for your feedback on your experience at Hope & Harmony Therapy. If you would prefer that Hope & Harmony Therapy not contact you, simply inform your counselor and your preferences will be respected.

Name of Person Financially Responsible to Hope & Harmony Therapy:

_____

Please read following statements carefully and initial as applicable:

Financial Responsibility:

Private Pay (subject to Late Cancellation/No Show fee):

_____ I understand that Hope & Harmony Therapy's current, standard rate is $120.00/session and that I am opting to pay for services with cash, credit, check, or flexible spending/health savings account at the current private pay rate of **$**_____ prior to each session. I understand I will not require Hope & Harmony Therapy to verify my insurance benefits or file accordingly.

Employee Assistance Program, Aetna, BCBS

_____ I am requesting that Hope & Harmony Therapy, LLC verify my insurance benefits with _____ and file accordingly. I understand the standard, current rate applies. I give my permission to Hope & Harmony Therapy, LLC and/or third party billing company to disclose certain information to my insurance company, such as diagnosis, treatment plan (dates of service, services performed, etc.) and any other information requested by my Employee Assistance Program/Insurance Company as needed in order to process my claim accordingly.

I acknowledge that I have read this document in its entirety and understand the above policy above information regarding the services provided client rights, and limits of confidentiality. I have read, understand and accept the Financial Responsibility & Appointment Cancellation Policy Statement. I also acknowledge my review of HIPAA & Additional Privacy Information available in the office.

Signature of Legal Guardian	Printed Name of Legal Guardian	Date

Signature of Therapist	Printed Name of Therapist	Date