# Brazoria County Counseling Center

120 E. Plum Angleton, Texas 77515
979 549 0889 - office
979 549 0878 - fax

New Client,

Please fill out all paperwork included in this packet.

**If you are using EAP (Employee Assistance Program)**, please include the following information:

- EAP Company
- Authorization Number
- Time frame EAP sessions are valid

Once **ALL** EAP sessions are used and you wish to continue with counseling services, we will need to file future sessions with your primary health insurance. In case you should continue, please **ALSO** complete the Insurance section (Insurance company name, Member ID #, Group #, and insurance company phone number usually found on the back of the insurance card),
Providing the requested insurance information will allow us to verify benefits prior to your appointment. We will then be able to provide you with the most accurate information available to us in terms of co-pay and deductible information once EAP sessions are used.
Please sign all pages where highlighted.
If you are returning this packet via e-mail prior to your appointment, please include a copy of your insurance card, driver's license, and credit/debit card you will be placing on file with our office.
We look forward to meeting you!

Thank you in advance,
Brazoria County Counseling Center

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**120 E. Plum Angleton, Texas 77515**
**979-549-0889**

## Client Information

**Name: _____ _____**
Last Name First Name
**Address: _____ City: _____ State: _____ Zip: _____**

**Home phone _____ Cell Phone _____EMAIL: _____**

**Sex:** (Circle One) **M F Birthday: _____ Soc Sec #: _____**

**Marital Status:** (Circle One) **Single Married Separated Widowed Divorced OR Child**

**Place of Employment & work#:_____**

**Who may I thank for referring you? _____**

**In Case of Emergency, Please Notify _____ Phone: _____**

**IF CHILD: Parent's name, Place of Employment and Phone number:**

**Mother_____**
**Father: _____**

**Student at: _____ School Phone # _____**
**School Address**: _____

**Insurance Information:**
**Name of Primary Insured: _____ D.O.B _____ S.S # of Primary Insured: _____**

**Address of Primary Insured: _____**

**Insurance Company name: _____ Ph. # for Eligibility:_____**

**Group #: _____ Subscriber I.D. #: _____**

**EAP Name: _____ Auth #_____ # of sessions: _____ Phone #:_____**

**Effective dates for EAP: _____ to _____**

I the undersigned, certify that my dependent or I have insurance coverage with: _____ and assign directly Brazoria County Counseling Center all insurance benefits, if any otherwise payable to me, for I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Brazoria County Counseling Center to release all information necessary to secure the payment of benefits. I furthermore authorize the use of this signature on all insurance submissions.

_____ _____ _____
**Responsible Party Signature** **Relationship to patient** **Date**

**Brazoria County Counseling Center, LLC**

**Policy Regarding Collection of: Co-Payments, Deductibles, Fees and Denied Insurance Claims**

As a client of BCCC, you are responsible for the payment of therapy and counseling fees. If you choose to use your health insurance coverage in connection with therapy and counseling services, the administrative staff will attempt to assist you in filing and processing such insurance claims. However, it is your insurance policy and therefore your responsibility to make sure your insurance claims are paid.

Fees for therapy and counseling services including co-payments, deductibles and insurance claims denied for any reason, unless otherwise provided for will be your responsibility. Fee will be charged against the credit card account as set forth in the Cancellation Agreement.

**If your psychotherapist is ever asked to testify in court on you or your child's behalf, you are responsible for the professional testimony fee of $100.00 an hour.**

**If for any reason you do not pay or your account becomes delinquent, we will forward your delinquency to a collections agency and you will be responsible for any fees that may apply.**

**********  **Confirmation calls from our office are just a courtesy. It is *NOT* our responsibility to make sure you will be here. If you do not give enough notice, there will be a fee for a no show or late cancellation. If you are more than 15 minutes late you will have to reschedule and pay for that appointment missed.** **********

## Cancellation Agreement

As either the patient in therapy, and/or the person responsible for the payment of fees in connection with counseling services or professional court testimony, I agree that all counseling appointments made with **BCCC** will be kept. However if, for **ANY** reason, any scheduled appointment is not kept at the scheduled time, I agree to give **BCCC** no less than twenty-four hours advance notice. In the event BCCC **does not receive at least twenty-four (24) hours** advance notice of cancellation of any scheduled appointment, **regardless of the reason** for such cancellation, I agree to pay a **cancellation fee of $75.00**. I agree that the fee will be charged to the credit card account indicated below:

Visa ☐ MasterCard ☐ Other ☐ _____ ☐ **No Card (see below)**
Account Number _____
Expiration Date: _____/_____ (mm/yr)
VIN Number (3 digit code on back of card): _____
Name of Cardholder: _____
**Please print**
Billing address of card: _____
Date: _____

Signature of Cardholder/Responsible Party: _____
Print Name: _____
Signature of Therapist: _____

☐**No Card**

**I agree that I am fully responsible and will pay any counseling fees, late fees, no show fees or court testimony fees that may be associated with my account.**

**SIGNATURE_____ DATE_____**

# Brazoria County Counseling Center

**120 E. Plum Angleton, Texas 77515**
**979-549-0889**

Client Name: _____

## CONSENT FOR MENTAL HEALTH

I, the undersigned do hereby voluntarily agree to counseling services either by group individual or family counseling to be provided by Brazoria County Counseling Center. I am aware that the practice of counseling is not an exact science. As a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment that may be rendered. Further, I understand that evaluation and treatment may involve discussion of personal events in my own history that, at times, may be discomforting.

**Limitations on Confidentiality:**

Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage and most private health insurance plans is usually confidential information that this office may disclose only to authorized people. Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects.

The following are exceptions to confidentiality that every client needs to understand in advance.

If a counselor learns of child or elder abuse that is currently taking place or has the possibility of recurring, he or she is legally required to report that abuse to the appropriate authorities.

If a psychotherapy/counseling client discloses an intention to do something that is likely to harm him/her or others, the counselor is required to report that intention.

If a court order, other legal proceedings, or statute requires disclosure.

### BASIC RIGHTS FOR ALL CLIENTS

You have the right to impartial access to treatment regardless of race, religion, sex, age ethnicity, or handicap.
You have the right to considerate and respectful treatment and recognition of your personal dignity.
You have the right to a written statement of your rights.
You have the right to be informed of your rights in language you understand.
You have the right to participate in treatment decisions.
You may terminate services at any time unless legally prohibited from doing so.
You have the right to be informed of alternatives available when you leave treatment, and you will be given specific follow up recommendations outlined.
You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer.
You have the right to withdraw your permission at any time in matters to which you have previously consented.
You have the right to request the opinion of another clinician at your own expense.

## Grievance Procedure or Complaints

The therapist will provide services in a professional manner consistent with all applicable laws, rules, regulation guidelines and codes of ethics and conduct concerning the therapist and the client/therapist relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist.

You may also file a complaint concerning a therapist to:

**Texas State Board of Examiners of Professional Counselors**
**1100 West 49th Street**
**Austin, Texas 78756-3183**
**(512) 834-6658**

I certify that: (Check One)

_____ I have received a copy of this document prior to treatment.
_____ Staff has explained its content to me in a language I understand.

Signature:_____ Date:_____

## Behavioral Health / Medical Provider Coordination of Care

Please complete this form so Brazoria County Counseling Center may communicate with Primary Care Physician or Psychiatrist. If there is no physician/psychiatrist or do not want to disclose information, please indicate with an **"X"** at the bottom of the page and sign name.

Client's Name:_____ Date of Birth _____
Client's Home Address: _____ Daytime Phone #: _____

### Primary Care Physician or Psychiatrist Information

___ Client **does not** have a medical health provider.

Primary Care Physician's Name: _____ Physician's Address:_____
Primary Care Physician's Phone #:_____ Primary Care Physician's Fax #:_____

Current Treatment and Medications:_____

____Client **does not** have a Psychiatrist.

Psychiatrist's Name:_____Psychiatrist's Address:_____
Psychiatrist's Phone #:_____ _____Psychiatrist's Fax #:_____

Current Treatment and Medications:_____

### Client Authorization:

I understand that I am **NOT** required to sign this authorization as a condition of receiving services from Brazoria County Counseling Center Clinicians. The reason for disclosure is to facilitate continuity and coordination of treatment and may include the diagnosis of a mental health disorder. I understand I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier.
**Expiration Date**:_____

**I give my authorization**:
___ to release any applicable mental health information to my Primary Care Physician/Psychiatrist listed above.
___ to release any applicable medical information **FROM** my Primary Care Physician/Psychiatrist to Brazoria County Counseling Center.
___ I **DO NOT** give authorization to release any information to my Primary Care Physician/Psychiatrist.

**X** _____ **Date:** _____
**Client's Signature or Parent/Guardian's Signature**

**********

**FOR OFFICE USE ONLY- Clinician will complete this section to communicate to Physician/Psychiatrist.**

Name: Brazoria County Counseling Center Address: 120 E. Plum Angleton,Texas 77515
Phone #: 979 549 0889
Client's Diagnosis:_____
Comments: _____

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## HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from designated third-party payers.
* Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Client's Name _____ DOB: _____
(mm/dd/yy)

_____ _____
Signed (Patient or Legal Representative for Patient) Date:

_____
Legal Representative's Relationship to Patient