Gramercy Specialty Clinic
2312 Western Trails Blvd Ste D, 402 Austin, TX 78745
Phone: (512)777-2686 Fax: (512)777-2801

Counseling Intake Form

Each person attending therapy should complete a separate form.

Registration Information

How did you hear about us? ____

Client Information

Client Name : ______________________ Gender: ☐ Male ☐ Female Date of Birth: __________________

Mailing Address: ____________________________ City/State/Zip ________________________________

Home Phone: _______________ Work Phone: ________________ Email: ___________________________

How would you like to be contacted? ☐ Home ☐ Work Okay to leave a voicemail message? ☐ Yes ☐ No

Is it ok to discuss scheduling, send receipts & statements via email? ☐ Yes ☐ No

If yes, please provide the email address you would like for us to send receipts & statements to: _________________________

If client is a minor, please provide the name of the parents or legal guardians: ___________________________________

Emergency Contact

Emergency Contact Name: ________________________ Phone: _________________________

Relationship to client: ☐ Relative (specify) __________ ☐ Spouse/Partner ☐ Other (specify) ________

Referral Information

What are you hoping to achieve by engaging counseling services now? _______________________________________

____

Have you ever been to counseling before? ______ If yes, please describe when, where, how long and reason(s): _______________

____

Are you under the care of a doctor now? _______ Reason for doctor's care: ____________________________________

Are you taking any medication? ________ If yes, what kind? ____

Responsible Party (If Different Than Client)

Name: ___________________ Relation to client: ☐ Legal guardian ☐ Spouse ☐ Other

Billing Address: _________________________ City/State/Zip ___________________________

Billing Phone: __________________________ Ok to leave a voicemail message? ☐ Yes ☐ No

Email Address: __________________________ Ok to send receipts & statements via emails? ☐ Yes ☐ No

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** Receipts can be provided to clients upon request **

Insurance Information (Insurance Card Needed at Initial Appt)

Primary Insurance Company: ______________________________ Secondary Insurance Company: ______________________________

Copay: $______________________ Deductible: $__________________ Coinsurance: $_________________

Insurance ID #: ___________________________________ Covered Services: ______________________________________

Authorization Info: ____

***** ALL COPAYS & BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT *****

For your convenience, you may leave a credit card on file so that we may apply counseling-related charges as they accrue. **Please note that clients who engage in telehealth services must provide a credit card below so that we may collect counseling-related fees at the time of service.** Some clients prefer this option, as it allows for easy and convenient payment for services rendered. Receipts can be provided to the client upon request.

Credit Card Information

Please circle card type:

VISA MASTER CARD AMERICAN EXPRESS DISCOVER

Card #: ____

Card Holder Name: ______________________________

Expiration Date: _______________ CVV Code: _______

I hereby give consent to charge my credit card below for any outstanding balances such as deductibles, co-payments, fees or other amounts payable by me.

________________________________ ____________
Card Holder Signature Date

HSA Card Information

Please circle card type:

VISA MASTER CARD AMERICAN EXPRESS DISCOVER

Card #: ____

Card Holder Name: ______________________________

Expiration Date: _______________ CVV Code: _______

I hereby give consent to charge my HSA card below for any outstanding balances such as deductibles, co-payments & fees my carrier determines as payable by me.

________________________________ ____________
Card Holder Signature Date

Private Pay Option

Some clients prefer to use cash to pay for counseling-related services for a variety of reasons. In an effort to provide the best care that is sensitive to the diversity of our clients' needs, we offer a private (cash) pay option for those clients who are uninsured, as well as for those who have insurance plans that we do not accept.

Fees: The cost of a counseling session delivered by a fully licensed LPC or LCSW is $125. The cost per counseling service delivered by a masters level LPC Associate or Licensed Masters Social Worker (LMSW) is $100. These fees may include services rendered to individuals, couples & family counseling sessions. Please note that these are flat rate fees and are due at the time of service, regardless of the time

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increment assigned by the therapist. LPC Associates & LMSWs work under the supervision of a board approved supervisor, while LPCs & LCSWs practice independently.

Client Agreement / Informed Consent

Overview of Services: Counseling is a collaborative and therapeutic process that develops between you and a therapist. The purpose of this service is to work on different areas of your life and assist with your personal goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling and psychotherapy both refer to a supportive and guiding relationship with a licensed, professional practitioner who has undergone extensive training in order to be able to understand the dynamics of the human experience and psychological development. There are many different definitions and philosophies of psychotherapy, and each therapist will have their own unique approach to treatment in unison with your goals, desires and preferences.

Counseling activities are governed by the State of Texas Board of Examiners for Professional Counselors, the Texas State Board of Examiners of Marriage & Family Therapists, the Texas State Board of Social Worker Examiners, and the Texas State board of Examiners of Psychologists. Psychotherapy services are typically offered to children, adults, couples and families on a weekly basis.

Benefits: Research seems to indicate that active participation in therapy can yield a number of benefits. Counseling can provide a fresh perspective on a difficult problem or provide different alternatives for managing life's challenges. Although the standard of care requires that an intake session be conducted and that follow up sessions be scheduled, the therapeutic process will be unique to your particular situation. The benefits that you obtain from therapy will largely depend on how well you use the process and put into practice what you are learning. Some of the benefits from counseling may include developing a deeper sense of awareness and insight, reduction in symptomology, developing skills for improving your relationships and/or better management of life stressors. Some people find that participating in psychotherapy results in changes that were not anticipated or intended at the outset of services.

Risks: There are certain risks that can be associated with the counseling process that should be understood before work progresses. For example, some clients who engage counseling services may, for a time, experience uncomfortable feelings such as sadness, guilt, anxiety, fear, anger, frustration, loneliness or other difficult thoughts and/or feelings. Clients may recall unpleasant memories while in counseling and some clients have even reported noticing that some of their relationships have been affected as a result of therapy. Sometimes, a client's problems may temporarily worsen after the beginning of treatment, but it is important to note that most of these risks are to be expected when some people are making significant changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not yield the results that you initially desired from it so it is important to discuss any concerns that you may have with your therapist.

Confidentiality: Psychotherapy, counseling, assessment and associated services that are related to diagnosis, evaluation and treatment services provided by licensed professionals are confidential and protected under Texas state law. The law protects the privacy of all communications between a client and a licensed professional. In most situations, information regarding your treatment can only be released to others with your written permission. For your privacy, our clinic is not able to confirm that you are receiving services from our licensed clinicians to external parties unless you have signed a consent form for the person or entity that is waging the inquiry. If you know that a person or entity will be calling to verify that you are receiving services from us, please inform our staff ahead of time so that you may have an opportunity to provide written consent to release information on your behalf. You should also know that you may revoke your consent at any time.

Please be advised that there are legal limits to confidentiality and times in which a licensed professional is obligated to disclose pertinent information, as necessary, to the appropriate authorities and agencies as follows:

- If your therapist suspects that you pose harm to yourself or others
- If you inform your therapist that a child, elderly person or disabled person is being abused or neglected
- If disclosure is mandated by a state or federal court

Additional limits to confidentiality include:

- In the case of minors, parents or legal guardians have access to their child's records, unless that child is emancipated.
- Family or group counseling is not legally private and can be subpoenaed.

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● Therapists may occasionally discuss some of their cases anonymously with peer professionals for the sole purpose of improving the quality of services provided to the related client. In these instances, client names and other identifying information will be withheld and the information disclosed will meet the Minimum Necessary Standard.

Client records may be accessed by clinic staff exclusively to the degree necessary to perform their professional responsibilities regarding basic intake, scheduling and billing procedures. Furthermore, for clients who use insurance to pay for all or part of treatment, information regarding diagnosis and treatment must be shared with the insurance company. Clients are protected under the Federal Health Insurance Portability and Accountability Act (HIPAA), which ensures the confidentiality of all electronic information about you.

Email & Text Communications: When communicating with your therapist, it is necessary to understand that email and texts are not considered completely confidential means of communication; therefore, clients are encouraged to keep treatment-related information within the context of the therapeutic sessions.

Therapeutic Relationship: The client-therapist relationship is purely a professional one in which appropriate boundaries are maintained, despite the fact that close bonds may develop over the course of treatment. These professional boundaries are necessary for the maintenance of the therapeutic environment. As such, your therapist cannot be expected to participate in a social relationship or friendship of any kind that exists outside of the therapy room.

Time Parameters: Appointments are scheduled for specific time segments that are determined by the therapist. Being late for an appointment will count against this allotted time and the session will conclude at its normal stopping time.

Payment: Payment is due on the time of service. Payment may be made in person, if the client is attending services in our office; however, if a client is receiving virtual services via telehealth, then he/she/they must provide our office with a credit card in advance of the virtual services so that we may collect fees that may apply at the time of service.

Appointment Cancellation: Our staff realizes that on occasion, you may not be able to make a scheduled appointment. However, please remember that the therapist has reserved this time for you alone, so **our policy is to charge $35 for any session canceled with less than 24 hour advanced notice or missed without prior notification (no-show)**. This charge is NOT covered by your insurance company and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. Clients with 3 missed appointments may be subject to termination of care. Please contact our office directly or your therapist to make scheduling changes.

Termination: Counseling is voluntary. Both you and your therapist reserve the right to transfer/terminate services at any time for any reason.

Client Bill of Rights: Our clinic does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, disability or public assistance status.

Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available through our clinic and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance
- can expect complete information regarding his/her treatment plan and care in terms he/she can understand
- has the right to know 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 our clinic staff free from restraint, interference, coercion, discrimination or reprisal
- may expect courteous treatment from our clinic staff
- has the right to coordinate transfer of care when there will be a change of providers
- has the right to choose freely among available mental health professionals in the community and to change providers after mental health services have begun

Emergency/After-Hours: If you have a life-threatening emergency, please call 9-1-1 or go to your nearest emergency room. For mental health crises, you may call the Travis County 24/7 Crisis Hotline at (512)472-HELP or Psychiatric Emergency Services at (512)454-3521.

Grievance/ Complaint: You have the right to file a complaint if you have an unresolved concern regarding your therapy services/therapist, or any issue involving a staff member at our clinic. Grievances can be discussed with your therapist or can be submitted in writing to the Clinical Director at our clinic. To file a complaint against a licensee, you may also contact the appropriate licensing board listed below:

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● Texas State Board of Examiners of Professional Counselors: (512)834-6658
● Texas State Board of Examiners of Marriage & Family Therapists: (512)834-6657
● Texas State Board of Examiners of Social Worker Examiners: (512)834-6677
● Texas State Board of Examiners of Psychologists: (512)305-7709

Release of Records: The client record is legally the property of the clinic; however, clients may have access to information contained in the file, except in cases where the release of such information may be deemed harmful to the client's well-being. Information can only be released to others upon written consent of the client. Record requests and record transfer requests will be forwarded upon completion of a Release of Information Form and a payment of $15 processing fee for the first 25 pages of the record, plus $1.00 per page for documents exceeding the 25th page.

Court & Legal Proceedings: Our clinicians are not trained for, nor do they maintain records with the intended purposes of court involvement. In addition, the legal process is such that our therapists may be compelled to reveal information that could affect our clients negatively or undermine their therapeutic relationship. Should our therapists be called to court by a court order, or our records be subpoenaed, we will charge a $15 processing fee for the first 25 pages of the record, plus $1.00 per page for documents exceeding the 25th page. In the event that it is necessary, by court order or subpoena, for the therapist to testify before any court at a deposition, 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 services at the rate of $250 per hour and will be billed in 15 minute increments. An initial charge of $500 will apply to the client and must be paid to our office before the therapist may attend a court ordered judicial proceeding. This charge will cover the first 2 hrs of the therapist's court-related time and additional fees may apply if the therapist is required to stay at the court proceeding for longer than 2 hrs. These fees will apply even if the therapist is called to court but does actually testify or if the hearing is rescheduled but the therapist has already traveled to the court proceeding.

Preparation of Forms, Letters & Reports: Although the therapist is not usually required to generate letters or reports for their clients, it is at times beneficial for them to do so. In most cases, the therapist reserves the right to accept or decline the request for such documents. Please note that in the event that the therapist should accept to generate the requested documents(s), the client will be billed at a rate of $25 per 15 minutes increments used to create the letter or report. This means that if it takes the therapist 30 minutes to write a letter, then the client will be charged $50 for this service. The time spent by the therapist in fulfilling these documentation requests is not billable to the insurance companies.

Counseling Fees & Insurance Billing: Counseling services are performed by highly trained professionals who have completed a minimum of masters level graduate program in counseling or related field, and have obtained licensure from the state board of examiners. Fees are as follows:

● A flat fee of $100 will be assessed for individual, couples and family sessions rendered by an LPC Associate or LMSW. A flat fee of $125 will be assessed for individual, couples and family sessions rendered by an LPC or LCSW. Clients who are uninsured or who have insurance benefits that we are out-of-network with may pay cash/out of pocket for our services. Clients who elect to use their insurance for payment may need to pay additional copays, coinsurance and/or deductibles. We do not have the ability to waive copays, deductibles or coinsurance as this is a violation of the contract that we have with the insurance company. The client is responsible for any charges not eligible and/or covered by their insurance plan or HSA account.
● Cost estimation tools provided by the client's insurance company allow for the collection of coinsurance and deductible amounts at the time of service. This collected amount is based on an *estimate* of your out-of-pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and an explanation of benefits (EOB) is generated by the insurance company. Any underpayments made by an insurance company must be made in full by the client at the their next scheduled appointment.
● While our staff works directly with the insurance company as a courtesy to our clients, it remains the client's responsibility to understand their plan's limitations, deductibles and exclusions. For benefit coverage inquiries, clients are encouraged to call the customer/member service phone number on the back of their insurance card.
● It is the client's responsibility to provide our staff with updated information when their insurance policy changes or their coverage terminates. Clients will still be financially responsible for services rendered if their insurance coverage has terminated. By signing this agreement below, you agree to accept financial responsibility for all services rendered by your therapist in the event that your insurance company should not render payment for these services.

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I have read, understood, agree and consent to the conditions of service as stated in this agreement. I have also had opportunities to ask questions about and understand these policies.

____

Signature of Client Printed Name Date

Informed Consent for Telehealth Services

I ___________________________[name of client] hereby consent to engaging in telemedicine with my therapist at Gramercy Specialty Clinic as part of my counseling services. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that I have the following rights with respect to telemedicine:
(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of physical harm/violence towards self or others; and where a court of law should subpoena my mental health records via a court order.
I understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent. I also understand that my psychotherapy sessions must be confidential in accordance with regulatory laws that govern the scope of counseling work. Furthermore, I agree not to record any of my counseling sessions with my therapist; this means I will not record any audio or visual images of my sessions as doing so may compromise the confidentiality of our work together. Recording counseling sessions without my therapist's consent may lead to termination of counseling services with my therapist at Gramercy Specialty Clinic.
(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted by technical failures, or that the transmission of my medical information could be interrupted by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve. (4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. (5) I have a right to access my medical information and copies of medical records in accordance with Texas law.

In order to participate in the telemedicine program, I agree to keep a credit card on file to be charged once the visit is completed. By signing this consent, I agree to the charges on my credit card based on my insurance rates.

Credit Card #: ______________________________ Expiration Date: ____________ CVC: __________

I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.
Client Name (Printed): ______________________ Client Signature: ______________________ Date: _____
Name of Legal Guardian: _______________________ Signature of Legal Guardian: ________________

Client Initials _____