# INSURANCE INFORMATION – MINORS FORM (under 18 years old)

**Itisimportantthatyouthoroughlycompletethisformandprovideacopyofbothsidesofyourinsurancecard(s).**

**Therapist Name:**_____

## Client & Parent/Legal Guardian Information

Client Name:_____ Birth Date:_____

Parent/Legal Guardian Name(s):_____

Address: _____ SS#:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____

Employer:_____ Marital Status? ☐ Married ☐ Single ☐ Other

---

## Primary Insurance Information

Name of Insured:_____ SS#:_____ Birth Date:_____

Employer of Insured:_____ Insurance Company:_____

Policy#:_____ Group#:_____

Customer Service Phone: _____ Mental Health Phone:_____

---

## Secondary Insurance Information (If Applicable)

Name of Insured:_____ SS#:_____ Birth Date:_____

Employer of Insured:_____ Insurance Company:_____

Policy#:_____ Group#:_____

Customer Service Phone: _____ Mental Health Phone:_____

---

## EAP (If Applicable)

Name of EAP: _____ Phone # of EAP:_____

Authorization #:_____ Sessions Authorized:___ From_____ To_____

---

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that HCCC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold HCCC liable for insurance nonpayment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. HCCC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request assigned benefits to be paid to HCCC and/or the provider indicated above.

Signature of Legal Guardian/Parent/Insured:_____ Date:_____


**Houston Center for Christian Counseling**

**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827

**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827

www.christiancounselinghouston.com

# INTAKE FORM -MINORS (under 18 years old)

## Child's Information

Child's Name:_____ Birth Date:_____

School:_____ Grade:_____ Teacher:_____

Child lives with:_____

History of alcohol or drug use? ☐ YES ☐ NO History of self-harm? ☐ YES ☐ NO

If so, briefly describe nature of use and/or nature of self-harm:

_____

## Parent's Information

Mother's Name:_____ Age:_____ Occupation:_____

Address:_____ Phone:_____

Employment Status:_____ Employer's Name:_____

Significant medical concerns:_____

Current or past psychiatric diagnosis or treatment:_____

History of alcohol or drug use? ☐ YES ☐ NO History of arrest? ☐ YES ☐ NO

If so, briefly describe nature of use and/or nature of arrest:

_____

Father's Name:_____ Age:_____ Occupation:_____

Address:_____ Phone:_____

Employment Status:_____ Employer's Name:_____

Significant medical concerns:_____

Current or past psychiatric diagnosis or treatment:_____

History of alcohol or drug use? ☐ YES ☐ NO History of arrest? ☐ YES ☐ NO

If so, briefly describe nature of use and/or nature of arrest:

_____

## Emergency Contact Information

1. Name / Phone #: _____ / _____ Relationship:_____

2. Name / Phone #: _____ / _____ Relationship:_____

Do these people know the child is in counseling? 1. ☐ YES ☐ NO 2. ☐ YES ☐ NO

**Houston Center for Christian Counseling**

**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827

**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827

www.christiancounselinghouston.com

## Family Information

Who brought the child for counseling?_____

Who is the legal guardian for the minor client?_____

What is your relationship to the child if none of the above?_____

Are there any other agencies involved with the family (CPS, Courts, etc)? ☐ YES ☐ NO

Briefly describe the nature of those cases: _____

For parents who are divorced, please state custody agreements: _____

***Divorce decree or temporary orders must be provided to therapist before the child can be seen.***

Is ex-spouse (biological parent) aware that you are bringing the child for counseling? ☐ YES ☐ NO

If not, please explain: _____

**Please list all members of the child's immediate family & non-family members living in the household:**

| | Name – Relationship | Birth Date – Age | Gender |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

**Step-Parentor Legal Guardian's Information (IfApplicable)**

Step-Parent/Guardian's Name:_____ Age:_____ Occupation:_____

Employment Status: _____ Employer's Name:_____

Medical or mental health concerns:_____ History of arrest? ☐

History of alcohol or drug use? ☐ YES ☐ NO

If so, briefly describe nature of use and/or nature of arrest:

_____

Step-Parent/Guardian's Name:_____ Age:_____ Occupation:_____

Employment Status: _____ Employer's Name:_____

Medical or mental health concerns:_____ History of arrest? ☐

History of alcohol or drug use? ☐ YES ☐ NO

If so, briefly describe nature of use and/or nature of arrest:

_____

## Child History

Please identify pediatrician name & contact information, medication, dosages and times taken:

Has the child received a previous mental health diagnosis? ☐ YES ☐ NO
If yes, provide person who diagnosed, date, and diagnosis:

If adopted, does the child know of adoption? ☐ YES ☐ NO
If yes, provide age of the child at the time of the adoption: _____

Has the child ever been or is s/he currently in foster care? ☐ YES ☐ NO
If yes, please describe: _____

Were there any problems or complications during pregnancy or birth? ☐ YES ☐ NO
If yes, please describe: _____

Has the child experienced any form of abuse (physical, emotional, sexual)? ☐ YES ☐ NO
If yes, please describe: _____

Has the child experienced any significant trauma or losses? ☐ YES ☐ NO
If yes, please describe: _____

Has the child experienced any divorces or separations? ☐ YES ☐ NO
If yes, please describe: _____

Has the child experienced difficulties at school or daycare? ☐ YES ☐ NO
If yes, please describe: _____

Does the child generally get along with other children his/her own age? ☐ YES ☐ NO
If no, please describe: _____

Does the child generally get along with adults? ☐ YES ☐ NO
If no, please describe: _____

Does the child have unusual eating or sleeping patterns? ☐ YES ☐ NO
If yes, please describe: _____

## Spiritual Information

Does the child consider him/herself a Christian? ☐ YES ☐ NO
Do you consider yourself a Christian? ☐ YES ☐ NO

Do you desire prayer and/or Bible reading to be part of the child's counseling? ☐ YES ☐ NO

What church do you attend?_____ How often?_____

## Legal Information

History of arrest (for child)? ☐ YES ☐ NO Are there any legal cases pending? ☐ YES ☐ NO

If yes, please briefly describe the nature: _____

## Counseling Details

Briefly describe the concerns you have regarding the child:

_____

_____

_____

_____

_____

_____

How long has the problem existed?

_____

_____

What attempts have been made to resolve the difficulties?

_____

_____

What are the goals you hope to achieve through counseling?

_____

_____

_____

Has the child been to counseling before? ☐ YES ☐ NO

If yes, identify counselor and the dates:

_____

_____

Briefly explain the nature and outcome of that counseling**:**

_____

_____

*I agree that the information I have provided is accurate and true, to the best of my ability.*
*I am aware that in cases of divorce, the divorce decree must be given to the therapist in order for the child to be seen by the therapist.*

Parent/Legal Guardian Signature:_____ Date: _____

**Houston Center for Christian Counseling**
**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827
**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827
www.christiancounselinghouston.com

# PROFESSIONAL SERVICES AGREEMENT

We are pleased that you have chosen Houston Center for Christian Counseling (HCCC). This form gives you some information about our professional relationship. You are encouraged to ask the therapist you selected and booked an appointment with any questions regarding their background, credentials, professional experience or philosophy.

## Confidentiality Information

HCCC is concerned about confidentiality. As Christian counselors, we believe God expects us to be trustworthy and we believe it is God's will for his people to know safety and security. It is the goal of HCCC to provide an environment in which our clients may place their trust and confidence. Under both federal and state law, confidentiality means communication with your therapist and any records pertaining to your identity, evaluation, or treatment will be held in confidence. As a group practice of independent therapists, your medical record is the responsibility and property of your individual therapist, not HCCC. Where state and federal laws differ, therapists comply with the stricter standard to ensure that your right to confidentiality is respected at all times. Also, beyond the law, we know that a sense of safety and security are necessary to the process of healing in which our clients are engaged. Through holding to God's commands and by complying with federal and state laws, HCCC will maintain confidentiality to the fullest extent personally and professionally. You have a right to confidentiality. Please find attached our Confidentiality Policy and Privacy Practices. It is your copy to keep and states more fully our policies and practices and your rights therein.

**Please read our Confidentiality Policy and Privacy Practices before signing this agreement.**

If you believe the Confidentiality Policy and Privacy Practices document does not answer all your questions regarding confidentiality, talk with your therapist about any concerns you may still have. Your signature at the end of this document serves as your consent to use your personal health information for routine practices according to the law for treatment, payments, and health care operations. You may revoke this consent in writing at any time, except to the extent that HCCC has taken action relying on this consent.

## Rights and Responsibilities

**Rights**

You have a right to be provided with professional and respectful care. You have a right to know your therapist's assessment of the problem, the recommendation of treatment, and the resources available to help deal with your situation. You also have the right to refuse any suggestion.

**Responsibilities**

1. To be honest, open and willing to share your concerns.
2. To ask questions when you don't understand or need clarification.
3. To discuss any reservations you have about your treatment plan.
4. To follow the agreed upon treatment plan.
5. To report changes or unexpected events related to your problem.
6. To keep appointments whenever possible to call or cancel within 24 hours prior to your appointment. (See "Payment Information" for details about being charged full session fee for appointments not cancelled with 24 hour notification)

*Remember, you are responsible for your thoughts, feelings, actions, and growth.*
*We are here to help facilitate growth to the best of our ability.*


**Houston Center for Christian Counseling**

**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827
**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827
www.christiancounselinghouston.com

## Payment Information

The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professional services.

The fee for a 50-minute therapy session is $150.00. It is the same for individual, couple, or family therapy.

**Payment is due at the time of service.**

As a courtesy, HCCC will file your insurance claims with your signed consent. HCCC charges full fee for missed appointments and appointments that are cancelled without 24 hour notification. Each of these payment requirements are discussed below.

**Insurance**

1. If you have managed care or employee assistance through your employer or a private policy, HCCC will file your insurance with your consent as a courtesy. Fill out the insurance information form in its entirety and sign if you wish us to file as a courtesy.

2. Co-payments must be made at the time of service. Deductible amounts are due at time of service where applicable.

3. If you are seeing a provider that is in your managed care network (In Network), you fee will be the negotiated rate as stated in the contract between the network and your therapist.

4. If you are seeing a provider that is not in your managed care network (Out of Network), you are responsible for amounts your insurance does not pay up to $150.00 for each 50-minute therapy session.

5. If you authorize this office to file insurance by your signed consent, we will do so, but you must understand that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and ensure your carrier remits payment. If a problem occurs with your claim, you will be required to make payment or establish a written financial payment plan with our office until your insurance problem is resolved.

**Payment Agreement**

1. As a courtesy to our clients, HCCC submits charges to contracted insurance plans. We are obligated to collect client responsibility amounts such as co-payment, co-insurance, deductible, and any non-covered services at the time of service. Sometimes, exact coverage cannot be determined until the insurance company receives the claim.

2. For your convenience and to simplify billing, HCCC maintains credit or debit cards securely on file for late cancellations and missed appointments without 24 hour notice and insurance claims unpaid after 60 days. If services provided are determined by your health insurance plan to be fully or partially non-covered for any reason, you agree to waive your contractual coverage and agree to be responsible for the charge. If for any reason your health insurance company does not pay our office within 60 days, we will submit the outstanding charges to the credit card on file.

3. There is a $35.00 service charge for returned insufficient fund checks. After the second insufficient deposit we will only accept cash for payments for services until the insufficient check and service charges are paid in full.

4. All sessions will incur a $3.00 administrative fee. As a courtesy, clients paying by ACH (Electronic Draft) will receive a $3.00 discount. To pay by ACH (Electronic Draft), please provide us with a voided check and fill out the ACH form available at the front desk.

## Payment Information (Continued)

**Appointment Cancellation Policy**

Twenty-four (24) hour notification is a required respect to the therapist who is reserving time for you and to other clients who are on a waitlist for appointments. You must give 24-hour advance notification for cancelled appointments. This advance notice is standard in our profession and health care in general.

**If you cancel or miss an appointment without 24 hour notification, you will be charged your full session fee.**

**Your credit card or debit card will be kept on file for missed appointments or late cancellations.**

HCCC has a 24 hour answering service that records time and date of your call to assist you in cancelling appointments in a timely manner.

Your card on file will be charged following the missed appointment or late cancellation. If you think there is an error, contact our office immediately.

## Signature for Professional Services Agreement

I do voluntarily agree to participate in the assessment and counseling as offered by Houston Center for Christian Counseling and my selected therapist. I am aware that treatment often involves family therapy or education which will be recommended if the therapist deems it important to the healing process. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in the document.

I consent to the use of my personal health information for routine practices for treatment, payment, and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices informational form, which I have received.

I have read and agree to the payment information as stated in this document.

**I understand that my credit or debit card on file will be charged my full session fee for late cancellations and missed appointments without 24 hour notice and insurance claims unpaid after 60 days.**

By my signature below, I accept all the terms and conditions as stated in this document.

Client's Name:_____ Date:_____

Client's Signature:_____

**Houston Center for Christian Counseling**

**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827

**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827

www.christiancounselinghouston.com

# AUTHORIZATION AGREEMENT FOR BILL PAYMENT

This authorization is for the patient responsibility portion of your bill. For contracted insurance, this will be the amount remained after insurance payment and adjustment by your insurance company. We acknowledge that the origination of transactions to your account must comply with the provisions of U.S. law.

Client Name:_____
(Please Print)

Cardholder's Name: _____
(If different from client)

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ Security Code:_____
(Month/Year) (Digit Code)

Type of Card: (Please circle one) MasterCard Visa Discover American Express

I authorize Houston Center for Christian Counseling to keep my signature on file and to charge the credit card identified above for the balance of charges not paid by my insurance company 60 days or more following date of service. This is for all treatment provided for the above named client.

Clients that are scheduled must leave a credit card on file or leave a cash payment of $150.00 prior to seeing a therapist.

**No credit card charge will be made until 60 days or more following date of service.**

**At any time, I may elect to pay my account in full to prevent this authorization from being activated.**

I assign my insurance benefits to Houston Center for Christian Counseling. I understand that this form is valid unless I cancel the authorization through written notice to Houston Center for Christian Counseling.

_____ _____
Signature authorizing bill payment on card Date

**Houston Center for Christian Counseling**
**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827
**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827
www.christiancounselinghouston.com

## Signature for Professional Services Agreement (OFFICE COPY)

I do voluntarily agree to participate in the assessment and counseling as offered by Houston Center for Christian Counseling and my selected therapist. I am aware that treatment often involves family therapy or education which will be recommended if the therapist deems it important to the healing process. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in the document.

I consent to the use of my personal health information for routine practices for treatment, payment, and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices informational form, which I have received.

I have read and agree to the payment information as stated in this document.

**I understand that my credit or debit card on file will be charged my full session fee for late cancellations and missed appointments without 24 hour notice and insurance claims unpaid after 60 days.**

By my signature below, I accept all the terms and conditions as stated in this document.

Client's Name:_____ Date:_____

Client's Signature:_____

## PERMISSION TO CONTACT VIA EMAIL OR TEXT

From time to time we may contact you via email & or text about your appointment times with your permission. We will always be discreet; the name of this office will not be used in our correspondence. For example, we would say, "Reminding you of your appointment with (therapist name) on Tuesday, March 17 at 2:00pm. Please call 281-277-8811 to confirm, cancel or reschedule."

I consent to being contacted via e-mail regarding my appointments. ☐ YES ☐ NO

E-mail address is_____

I consent to being contacted via text regarding my appointments. ☐ YES ☐ NO

Cell phone number is:_____

Do you want to receive news and updates about HCCC via email? ☐ YES ☐ NO

_____ _____ _____

Client Name (**please print**) Parent Signature Date

**Houston Center for Christian Counseling**

**Sugar Land Office** | 402 Julie Rivers Drive | Sugar Land, TX 77478 | P: 281-277-8811 | F: 281-277-8827

**Katy Office** | 609 Park Grove Drive, Unit B | Katy, TX 77450 | P: 281-398-0022 | F: 281-277-8827

www.christiancounselinghouston.com

# Confidentiality Policy and Privacy Practices

## Please retain this form for your records.

Houston Center for Christian Counseling (HCCC) is concerned about confidentiality. We believe a sense of safety and security is necessary to the process of healing in which our clients are engaged. It is the goal of HCCC to provide an environment in which our clients believe they can place their confidence and trust.

Under both federal and state law, confidentiality means communication with your HCCC therapist and any records pertaining to your identity, evaluation and treatment will be kept secure and private. Where federal and state law differs, we comply with the stricter standard to ensure that your right to confidentiality is respected at all times.

Examples of disclosure allowances under federal and state law for treatment, payment and healthcare operations are as follows:

- The therapist will disclose necessary information and notify authorities and other third parties when there is reasonable suspicion a minor child (under 18 yrs), an elder person (65 yrs and older), or otherwise dependent adult (any age) has been harmed.
- The therapist will disclose necessary information and notify authorities or other appropriate parties when the client has directly admitted serious and imminent suicidal threats.
- The therapist will disclose necessary information and notify authorities or other appropriate parties when the client has directly admitted harmful acts or threatened action that is serious, imminent and attainable against a clearly identified third person or persons.
- Therapists may be required to make disclosures to insurance and third-party payers, employee assistance programs and managed care groups concerning client's diagnosis, session dates and where required, client symptoms and treatment objectives.
- Client communication and records must be disclosed when ordered by the court.
- Exceptions to confidentiality are made in specified civil law cases such as disclosures relevant to a parent-child relationship, e.g. , in a divorce action.
- If a client files a malpractice suit or a formal complaint with their licensing board against a therapist, confidentiality is waived.

Other issues relative to confidentiality that may be applicable in specific instances follow:

- Graduate Interns receive supervision from HCCC therapists to facilitate their development and to ensure excellent care for our clients. In these instances, written or other legal authorization has been obtained from the client and client identities are protected.
- Written records of client communications are stored in a way to protect confidentiality and privacy rights. Electronically stored records are protected by password restrictions, backup systems, virus security software and firewall protection.

A federal program called Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to put into writing any request you believe necessary to restrict possible misuse of your protected health information. All requests will be honored except as the law specifically outlines the use of your personal health information for treatment, payment and healthcare operations.

HIPAA states once you give consent for the use of your personal information for treatment, payment and healthcare operations by signing the professional service agreement, you may revoke the consent in writing at any time, except to the extent that HCCC has taken action relying on your prior consent. If we believe we cannot honor your written request for restriction of healthcare information, we will discuss our reasons with you and if necessary, terminate our professional agreement formally in writing.

Under HIPAA, you have the right to request in writing, receive and inspect copies of confidential protected health information held in this office. HIPAA has guidelines regarding what information must be included in response to a request from a client. If the information you request is outside those guidelines, we have the right to deny your request. Requests within the guidelines will be honored; however, there is a reasonable charge for labor and copying, and reasonable time for preparation must be allowed.

Under HIPAA, you have the right to amend any of your protected health information by a written request. If your written request is outside the laws' guidelines, we have the right to deny your request to amend records.

If you believe we do not follow the stated intentions laid out in this document and/or you believe your right to confidentiality has been violated, please talk with your therapist or the Center's office manager or director. If you wish, you may file a written complaint with our office. Address your concerns to:

Houston Center for Christian Counseling
Attn: Director
402 Julie Rivers Drive
Sugar Land, TX 77478

If there is no resolution, you may file a complaint with the Department of Health and Human Services, Office of Civil Rights. For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
Telephone: (202) 619.0257 Toll Free: 1 (877) 696.6775