INTAKE FORM

DATE_____ REFERRED BY_____

CLIENT NAME_____

DATE OF BIRTH_____ AGE_____ SEX M / F

ADDRESS_____
Street Apt# City State Zip Code

(Please indicate preference for receiving messages, there is no guarantee of confidentiality via phone/text or email)

___ PHONE ( ) _____ ___ EMAIL_____

OCCUPATION/EMPLOYER/OTHER _____

SPOUSE/SIGNIFICANT OTHER _____ CONTACT# ( ) _____

DATE OF BIRTH_____ OCCUPATION / EMPLOYER_____

EMERGENCY CONTACT (if different from above) _____

PHONE NUMBER ( ) _____ RELATIONSHIP TO CLIENT_____

I understand and agree I am a private client, personally responsible for payment of services rendered, at time of service. *Ashlee N Albart, MS, LPC, NCC does not file any insurance claims*. *Ashlee N Albart, MS, LPC, NCC is a non-participating provider in any insurance plan or is considered an out-of-network provider.* Your receipt should contain all information necessary for any insurance *[except Medicare or TriCare]* to consider reimbursement. If I have *Medicare with or without a supplemental insurance*, I will *not expect claims to be filed*. As well, I understand that *I am unable to submit my own claims to Medicare [new law as of 2008] or TriCare for reimbursement.* I certify that the above information is true and correct to the best of my knowledge.

_____ _____
SIGNATURE DATE

CLIENT RIGHTS AND RESPONSIBILITIES

RIGHTS:
You have the following rights:

- To participate in planning your treatment program.
- To the extent permitted by the law, to refuse specific treatment, procedures.
- To file a grievance, should you feel you are treated unfairly.
- The right to confidentiality and privacy as appropriate to your treatment setting.
- To be free from discrimination including race, religion, sexual preference, age or disability.

RESPONSIBILITIES:
Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following responsibilities:

- To provide accurate and complete information as needed for your treatment planning.
- To update any changes in information needed for your treatment planning.
- To make it known whether or not you understand your treatment plan.
- To actively participate in your treatment and indicate when you are unwilling and/or unable to comply with your treatment plan.
- To follow all rules and regulations established to maintain a safe treatment environment.

_____ _____
SIGNATURE DATE

CONSENT FOR EVALUATION AND TREATMENT

This handout is to provide you with clear information regarding practice policies. It is important that you understand this information so please ask any question you have about the information provided.

CONFIDENTIALITY: Treatment information is controlled by the client, but there are exceptions:
1) By law therapists are to take whatever actions seem necessary to protect people from harm.
2) Therapists are required to contact the Department of Human Services if there is a reason to believe that someone is abusing or neglecting children, or a dependent adult.
3) If you have been referred to a therapist by court, you can assume that the court wishes to receive a report of the evaluation. In such instances, you have a right to tell the therapist only what you want me to know and be aware of the information that may be requested.
4) If you are involved in illegal actions of any kind and inform the court of services that you receive from a therapist, you will be making your mental health an issue before the court. You may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received mental health treatment.
5) Most insurance companies (both in and out of network), other payers, or manage care companies require the provider to release information regarding diagnosis, type and place of service, date of service, treatment plan, or other confidential information.

BENEFIT AND RISK OF THERAPY: Therapy is an interactive process between the client and therapist. It is meant to promote change and understanding. Sometimes this process is very fulfilling but also can be emotionally difficult. You will be expected to contribute to decisions regarding interventions, including out of session tasks. You have the right to refuse or alter any intervention. You are encouraged to question the rationale of treatment if it is unclear to you. While I have every expecta-

tion of helping you determine and achieve personal therapeutic goals, any specific outcome cannot be guaranteed.

AFTER HOURS POLICY: In the event of an emergency, clients should call 911, or go to the closest emergency room. In cases of urgent care, you may call 830-433-7569. Routine questions, appointments and other non-emergency matters can be handled during your appointment or via text, however confidentiality cannot be guaranteed over text message.

CREDENTIALS: Information regarding provider credentials is available upon request.

BY SIGNING MY NAME BELOW I SHOW THAT I HAVE READ THE ABOVE INFORMATION AND IF NEEDED IT HAS BEEN EXPLAINED TO MY SATISFACTION. I HAVE HAD ALL MY QUESTIONS ABOUT FEES, CONFIDENTIALITY, INSURANCE OR OTHER MATTERS ANSWERED, AND HAVE RECEIVED A COPY OF THIS CONTRACT IF SO REQUESTED.

_____ _____

SIGNATURE DATE

FINANCIAL AGREEMENT

I am committed to providing you with the best possible care. In order to achieve these goals, I need your assistance and your understanding of your payment policy.

Payment is due at the time services are rendered. If you are unable to keep an appointment, notify me at 830-433-7569 as soon as possible. This will enable me to accommodate other clients and those on a waiting list. If you cancel 24 hours or less before your appointment time, or do not show for your reserved time, there will be a charge of your full session fee. This charge will be due before the next visit. Additionally, if a check is returned by your bank for insufficient funds, there will be a $25 charge.

The charge for the appointment does not cover other service fees. There may be charges for questionnaires or letters that are not normally required for billing or treatment purposes, lengthy phone consults, and record requests. For any legal depositions required, there will be a prepaid charge of $200 per hour, with a minimum of 2 hours and non-funded after scheduled.

In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees that might occur. The account will become delinquent after it has matured to 121 days from the date of service. If the account goes to collections, there will be an added 33% to the account balance. The office of A. Albart will determine the collection agency.

There is the option of a sliding scale for those clients that require financial assistance, the scale is based on an individual or household income and will be determined on a case by case basis.

By signing below you have agreed to all the terms in this financial agreement. The terms of this contract are contingent on any contractual agreement made between the provider and you, and any terms stated that violate the provider's contractual agreement are voided and/or non-applicable.

_____ _____

SIGNATURE DATE

CONFIDENTIAL CLIENT QUESTIONNAIRE

Briefly describe your reason for seeking help and your goals for treatment: _____

_____

_____

_____

Have you ever been admitted to a psychiatric hospital? ___No ___Yes
If yes, list reason for and date of admission:

_____

_____

Have you seen a mental health professional in the past? ___No ___Yes
If yes please list name of professional: _____

GENERAL HEALTH:
Do you have any medical problems? Please explain.

_____

_____

Please list any medications you take regularly

Name of Medication	Dose	Frequency

Current or expected legal involvement? Yes No
If yes, please explain:

_____

_____

Who do you live with:

_____

Describe your support system:

_____

_____

CANCELLATION POLICY

Cancellations for appointments should be made 24 hours in advance, when possible. Anything less than 24 hours makes it difficult to reschedule anyone else for that empty time slot. Because short notice cancellations result in revenue loss for the clinician, Ashlee Albart has requested that clients submit a credit/debit card number and/or a pre-filled/signed check to keep on file. If you cancel with less than 24 hours notice, your card will be debited your entire appointment fee or check filled in for that amount, and you will be notified of this charge. If you have a need to cancel your appointment for emergency purposes, the nature of the emergency will be considered before exacting a cancellation fee.

Sincerely,
Ashlee N Albart, MS, LPC, NCC

_____ _____ _____ _____
Credit/Debit card account number Expiration date Security Code Zip Code

VERIFICATION OF NOTICE OF PRIVACY POLICY

I, _____ agree that I have read and received a copy of Ashlee Albart's Notice of Privacy Practices.

_____ _____
SIGNATURE DATE

PRIMARY CARE PHYSICIAN/PSYCHIATRIST COMMUNICATION FORM

Communication between behavioral health providers and primary care physicians/psychiatrists is important to help ensure all clients receive comprehensive and quality health care. This information is not released without the client's consent. This information may include diagnosis and treatment planning if necessary. The client may revoke this consent at any point, in writing, except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

I agree to release information and communication with:

___My Primary Care Physician
his/her name & address is:
_____
_____
_____

___My Psychiatrist
his/her name & address is:
_____
_____
_____

I decline to release my information to:

___My Primary Care Physician ___My information to my psychiatrist

N/A: ___I do not have a Psychiatrist ___I do not have a primary Care Physician

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(Completed by provider)

This client was seen at my office for mental health treatment as a result of:

___Direct client call to my office
___Referral from Psychiatrist
___Referral from PCP
___Post Psychiatric inpatient admission
___Referral from insurance company
___Other_____

Treatment Plan:

This patient was last seen by me on _____ _____
Date Signature

_____ _____
SIGNATURE DATE

PRACTICE INFORMATION, OFFICE POLICIES, AND CONSENT TO TREAT

Ashlee N Albart, MS, LPC, NCC practice is exclusively an office-based psychotherapy practice. Ashlee Albart's does not do hospital work, perform emergency medical services, or provide after-office-hour care. Consequently, she strongly recommends that in addition to her care, you maintain a relationship with one or more physicians and a psychiatrist if necessary. *If the occasion arises when urgent care or emergency services are needed, contact your nearest urgent care or emergency room or call 911*, *where you can receive care from specialty trained professionals.*

NON-PARTICIPATING or OUT-OF-NETWORK Provider or NON-COVERED Benefits As Ashlee Albart does not participate with any health insurance carriers you are responsible for paying for all services at the time of service. If insurance coverage is available for the services rendered, a receipt with the required information is provided, which you can attach to an insurance claim form and mail to your insurance company. You are entitled to know the cost of all services and procedures in advance.

Please Initial _____

PAYMENT| DISHONORED CHECKS You are responsible for payment of charges at the time of service. Our office accepts cash (exact change), personal checks, Master Card, or Visa. If your check is returned (e.g., refused for insufficient funds), you will be required to pay an additional fee of $25.

Please Initial _____

MISSED APPOINTMENTS It is important that you appear for all scheduled appointments. You will be responsible for paying a missed appointment fee your full appointment cost if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation. This policy is aimed at minimizing the waiting time and ensuring availability of prompt care.

Please Initial _____

RELEASE OF MEDICAL INFORMATION Any services or communications with Ashlee Albart is considered confidential; any disclosure of information and/or records, related to your care, will only be done by your signed authorization request and approval. ***Please Initial _____***

Ashlee Albart makes no representations, claims or guarantees that you will be helped with your mental health problems or conditions by undergoing treatment here. However, she will do her best to help you accomplish your mental health care and wellness goals. Ashlee Albart believes that your involvement in your treatment is essential and sees this relationship as a partnership.

I have executed this consent freely and willingly, and understand its provisions. I have read, understand and agree to the above. I recognize that Ashlee N Albart, MS, LPC, NCC will rely upon my execution of this document as my consent for treatment.

FEES* You will be informed of any services requiring additional payment before the services are rendered and may request a receipt to submit to your insurance company for any covered services. Please talk with Ashlee Albart if you need consideration for reduced fees.

Initial Individual Counseling-50 mins-$125
Individual Counseling-50 mins-$100
Initial Family/Couples Counseling-50 mins-$150
Family/Couples Counseling-50 mins-$125
Letters/Paperwork-$25/15mins
Phone calls <10mins-No charge; >10mins-$25/15mins
Return check fee-$25
Photocopies-$0.15/page

Certain services (e.g., family conferences, etc.) may entail additional fees.
* fees are subject to change

_____ _____
SIGNATURE DATE

AUTHORIZATION TO USE/DISCLOSE HEALTH CARE INFORMATION

910 Gruene Rd, Bldg 1 New Braunfels, TX 78130
Telephone: 830-433-7569 Fax: 830-625-0603

Client Name:_____ **Birth Date**:_____

I request and authorize Ashlee N Albart, MS, LPC, NCC to exchange and release health care information described below with:
Name:_____ at _____

Address:_____

City_____ **State**_____ **Zip**_____

Please initial to specifically authorize the use and/or disclosure of the following psychiatric records:

___Initial Psychiatric Evaluation **___Out-Patient Progress Note**
___Discharge Summary **___Other**_____
___Verbal Discussion of Case

The requested records or information is about health care provided during the following approximate time frame:

Purpose(s) of this use/disclosure:_____

Authorization expires:_____, or if unspecified 6 months from the date of the signature below.
(Date)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Ashlee N Albart, MS, LPC, NCC.

I understand that Ashlee N Albart, MS, LPC, NCC may not condition treatment, payment, or enrollment or eligibility of benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

I understand that my express consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health or drug/alcohol treatment or use.

_____ _____
SIGNATURE DATE

AUTHORIZATION TO PAY BENEFITS TO ASHLEE N ALBART, MS, LPC, NCC

I hereby authorize Ashlee N Albart, MS, LPC, NCC to file any medical claims on my behalf. I authorize payment to Ashlee Albart, for services rendered to my dependents or me. I also authorize this office to release any information necessary to expedite out-of-network insurance reimbursement.

_____ _____
SIGNATURE DATE

****Complete this form only if the client is a minor or an adult dependent****

AUTHORIZATION FOR EVALUATION AND TREATMENT OF MINORS AND ADULT DEPENDENTS

I certify that I am the parent or legal custodial guardian of _____ who is a minor or adult dependent.

_____ _____
SIGNATURE DATE

I authorize, Ashlee N Albart, MS, LPC, NCC to provide mental health treatment to _____. Such treatment may include, but is not limited to individual psychotherapy, group treatment, family therapy, or specialized therapeutic procedures, which are generally accepted in the field of mental health.

Client Signature_____ Date _____

Parent/Guardian Signature _____ Date _____

Printed Client Name: _____ Date of Birth_____

REDUCED FEE AGREEMENT

In psychotherapy, financial matters are addressed directly and confidentially. This agreement is intended to assist you in potentially making alternative arrangements in paying the standard session fee. Ashlee Albart has the policy to maintain a percentage of client caseload for reduced fee requests. Reduced fees may not be eligible for reimbursement through a health insurance policy, please check with your provider regarding out of network benefits.

Client Name: _____

Reason for Request: _____
_____
_____

Dependents #: _____ Estimated Gross Annual Household Income: _____
(The amount you earn before taxes, proof may be required)

Reduced Fee Policy: Requests will be evaluated based on need and the number of reduced fee positions that are available at the time. Fees will be reevaluated at a predetermined date.

Client Responsibility: Reduced fee services are accepted on the basis of the "honor system," so it is expected that you will notify Ashlee Albart as soon as you can increase the amount of your payment. Incremental increases are allowed.

If there is a late cancel or no-show, the first time will be billed at the reduced scale fee, however subsequent occurrences will be billed at the full rate. If there are consecutive no-shows or late cancellations, without significant cause, you will no longer be eligible to receive the reduced fee rate.

Waiting List: If you request a reduced fee and there are no positions available, you can be placed on a waiting list and will be informed of an opening on a first come first serve basis.

Equal Treatment: You are entitled to the full benefits of therapy, despite this reduced fee agreement.

Phone and Email Contact: Other than for routine scheduling, phone and email contact will be charged on a prorated basis in increments of 15 minutes.

Agreed Rate: Individual 50 min: $_____ Couples/Family 50 min: $_____

Re-negotiation Date: _____

_____ _____
CLIENT SIGNATURE DATE

_____ _____
THERAPIST SIGNATURE DATE