Family &
Youth Institute, LLC

25511 Budde Rd., Marimed Bldg., 401-402
Spring/The Woodlands, TX 77380
Phone: 281-748-0233
*Email: **familyyouth1@hushmail.com***
http://familyandyouthinstitute.com

CLIENT NAME:_____**: DOB:** _____**APPT. DATE:** _____ **TIME:**_____
THERAPIST NAME:_____ **THERAPIST SIGNATURE:**_____

FAMILY & YOUTH INSTITUTE & CONTRACT THERAPIST

Counseling and Psychotherapy - Client Services Disclosure & Informed Consent

Welcome to the practice of Family & Youth Institute. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information. We can discuss any questions you have. *When you sign this document, it will also represent an agreement between us.* **You may revoke this Agreement in writing at any time**. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claim made under your policy; or if you have not satisfied any financial obligations you have incurred. _____ ***(Initial and date)***

Counseling and Psychotherapy Services
The decision to begin counseling is one which may have important consequences for the rest of your life. Research has shown that when individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve good results. The therapy process calls for a very active effort on your part during and in between sessions in order for it to be successful. **Noncompliance and/or failure to participate fully in therapeutic processes may lengthen time needed in therapy, delay progress toward your goals, and/or contribute to unforeseen negative outcomes**. **You do have the right to refuse to participate in therapy**.

Psychotherapy varies depending on the personalities of the counselor, you the client, and the particular challenges you are experiencing. It can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience a variety of uncomfortable feelings. The benefits from therapy often lead to better relationships, solutions to specific challenges, and significant reductions in feelings of distress. There are no guarantees as to what you will experience or the subsequent outcome. Your input and comfort level are important in deciding whether you wish to continue in therapy. Therapy involves a large commitment of time, money, and energy, so it is helpful to be careful and deliberate about choosing a therapist. If you have questions about procedures, it should be discussed whenever they arise. If your doubts persist, we will be happy to discuss them and/or refer you to another mental health professional for a second opinion. _____ ***(Initial and Date)***

1. **Confidentiality** – The law protects the privacy of all communications between a client and a counselor. In most situations, information about your treatment can only be released to others if you sign a written authorization form that meets HIPAA regulations. It is very important that those seeking counseling carefully read and understand the following limits of confidentiality. What you reveal in our office is kept strictly confidential with the following exceptions:
    a. As a mandated reporter, State law requires reporting any known or suspected cases of child, elder abuse or neglect, including sexual abuse to the Texas Department of Human Resources. To protect others from harm I may have to reveal information about a client's treatment. Once such a report is filed, I may be required to provide additional information.
    b. If I determine the probability a client will inflict imminent physical harm on him/herself or another, I am required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization for the client in this instance.
    c. Professional misconduct by a healthcare professional must be reported. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released to substantiate disciplinary concerns.
    d. Insurance companies require certain information before they will pay either your therapist or the insured. This information usually includes but is not limited to: diagnosis, prognosis, and an estimate of the amount of time your therapist expects to treat you.
    e. in the event that a client fails to honor, after reasonable efforts to collect his/her debt, Family & Youth Institute, LLC may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic and accounting information. NO THERAPEUTIC INFORMATION WILL BE RELEASED.
    f. During the process of this business there will be times when we will share your information with the professional staff for clinical and administrative purposes. All of the staff members have been trained about protecting your privacy. They are under legal obligation to abide by this confidentiality and have agreed not to release any information outside of the practice without formal permission.
    g. Although you will probably meet with only one counselor, you are receiving services from the office of FYI. Consequently, you MAY have a paper file holding disclosure statements, demographic data, and consent to release information forms in our office. (Records beginning in 2019 will be stored electronically.) All therapists and staff may have necessary access to this file. Access to personal notes is not available to therapists not assigned to your case since we utilize THERAPY NOTES, LLC, an online, HIPPA compliant software, to manage and store client notes and financial information. FYI counselors and staff consult with one another about our work. In most cases, we need to share protected information within FYI for both clinical and administrative purposes, such as scheduling, records management, and quality assurance. _____**(Initial and date)**

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The situations below require a written consent or authorization before I am permitted to disclose your information.

a. The counselor-client privilege law protects your client information. Please consult your attorney or determine whether the court would be likely to order me to disclose information. I cannot provide your information without your or a legal representative's written authorization. However, if the Court subpoenas your records, I am legally bound to deliver them without your consent.

b. I may need to consult with another professional (i.e. your physician) about your evaluation or treatment. If any of these situations arise, I will make every effort to fully discuss it with you before taking action. I will need a signed release from you or your legal representative and I will limit my disclosure to what is necessary.

_____ ***(sign and date)***

I/We have read and fully understand the limits of my/our confidentiality. I/We have had a chance to ask my/our counselor for clarification regarding the limits of confidentiality.

2. **The Therapeutic Relationship** -- It is important that you understand that this is a professional relationship. Dual relationships are not allowed and may be harmful to clients as they may prevent therapeutic objectivity. While I appreciate your consideration, my professional duty to you precludes my ability to attend any of your personal events or accept any gifts. Your decision to retain me for services or to refer others to me for services is sufficient appreciation for the work that I do. Sexual contact between a client and a counselor is not part of any recognized therapy and is *illegal* in Texas. _____ ***(Initial and date)***

3. **Client Rights** - HIPAA provides you with rights regarding your records and the ability to disclose the information. These rights include requesting that I amend your record, putting restrictions on information from your professional record disclosed to others; requesting an accounting of most disclosures of protected health information you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this agreement with privacy policies and procedures. HIPAA also affords you the right that I keep health information about you protected. This is your clinical record which includes information about your reasons for seeking therapy, a description of issue(s) which impact your life, a diagnosis, goals set for treatment and progress, medical social treatment history, any past treatment record I receive from other providers, reports of any professional consultations, your billing records, and any reports sent to anyone, including your insurance carrier. _____***(Initial and date)***

4. **Professional Fees** – Billing rate for service at FYI may vary based on therapist credentialing level (full licensure versus intern licensure), service code (length and type of appointment), and educational level (Master's vs Doctorate). A schedule of fees is available for review upon request. **Generally, billing rates for fully licensed therapists (LMFTs, LPCs, LCDCs, and LCSWs) will be higher than those for licensed interns (LPC-Interns, LCSW-Interns, LMT-Associates, and LCDC-Interns). Billing rate for those with a Doctorate may be higher than those with a Master's degree.** Because it is our mission to make counseling services affordable for everyone, our Interns & LMFT Associates may provide private pay services at a reduced rate. Student interns may offer pro-bono sessions for qualified clients. Most licensed therapists and interns accept sliding scale pay for qualified clients with **$60 to $80 per 45 minutes** being the minimum payment accepted. Each therapist sets his/her own sliding scale minimum. Interns do not accept insurance but may accept sliding scale. Licensed therapists accept some private insurance and some Medicaid. Other services, including non-emergency phone calls over ten (10) minutes, generating reports, written **communication** requested by clients, consulting with other agencies and professionals at your request, and the time spent performing any other services you may request may be charged to you. These services are not covered under insurance typically. _____**(Initial and date)** ***)***

5. **Insurance-** Clients utilizing insurance will be expected to submit co-pays and/or deductibles the day of the visit. We also work with out-of-network clients who are covered by an insurance we do not accept. **These clients pay us at the time of the visit. Their fee will be the full cash pay cost of our services unless they meet qualifications for sliding scale AND they are working with a therapist who accepts payment on a sliding scale. We will either provide a receipt for services so the client can file with the insurance company for reimbursement, or we may, in some cases, file for clients. *Interns are not credentialed to accept insurance***. Therefore, we do not file insurance for their clients. Unless specifically disallowed by the insurance company, insurance may be filed for intern services when interns assist a credentialed therapist by seeing clients in conjunction with and directly under the supervision of the credentialed therapist who is their licensed supervisor. Note: Some mental health conditions and diagnoses are not reimbursable through insurance. Likewise, most insurance companies do not cover marriage or family counseling. Clients are expected to cover these costs personally. _____ ***(Initial and date)***

6. **Payment of all services rendered regardless of whether insurance pays or not.** For your convenience, we accept cash, checks, and credit cards. If payment is not made prior to the third session, your session may be cancelled and may not be rescheduled until payment is received. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. A $25 monthly billing charge will apply to unpaid accounts. A $45.00 fee will be charged for returned checks. _____***(Initial and date)***

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7. **Your insurance company does not guarantee payment of benefits.** They usually require clients to pay a standard amount before reimbursement is allowed (a deductible), and then they pay a percentage of the fee. We advise you to contact your insurance company to determine what your deductible is and what percentage of the fee they pay. The client remains responsible for *payment in full*, including any portion not reimbursed by insurance. **Though FYI does typically check insurance benefits and acquire preauthorization for covered sessions, the client remains the person primarily responsible for verifying insurance coverage benefits and acquiring authorization for coverage.** By signing this Agreement, you agree FYI can provide requested information to your carrier. *Please be aware we have no control over the confidentiality procedure of third parties once the clinical information leaves our office.* Typically, third-party payers generate computer records with this information. _____**(*Initial/date)***

8. **Cancellation of Sessions - In consideration of all parties involved, WE REQUIRE AT LEAST 24 BUSINESS HOURS ADVANCED NOTICE FOR CANCELLED APPOINTMENTS. FYI will collect fees for no shows and late cancellations**. Therapists set aside a personal time for each client. Therapist pay and FYI operating expenses are paid from client and/or insurance payment for those appointments, Notice of cancellations must be received at least **24 business hours** before the scheduled appointment time. Business hours are defined as being hours between 8 A.M. and 5:00 P.M., Monday through Friday. Appointments scheduled for Monday must be cancelled by Friday, between the hours of 8:00 A.M. and 5:00 P.M., 24 business hours before the Monday appointment time. This allows time to contact and schedule other clients who wish to be seen. **If you are able to reschedule a late cancellation at another appointment time during the same week,** you will not be charged for the missed appointment. **In the event you cannot reschedule within that same week, you will be financially responsible for the cancelled appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions**. After two no-shows/late cancellations, a client may be asked to pre-pay before future services are rendered. Clients who have prepaid agree to have the entire fee deducted from their pre-payment in cases of no shows and late cancellations. **NOTE: A FEE OF $80 MAY BE CHARGED TO YOUR CREDIT/DEBIT CARD ON FILE WITH US FOR ANY MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 BUSINESS HOURS PRIOR TO THE APPOINTMENT TIME. Saturday, Sunday, and cancellations after 5:00 PM are not considered within business hours. If FYI does not have a credit card on file, payment will be collected at the time of your next visit.** _____ **(*Initial and date*)**

9. **Court Proceedings** – If you ever become involved in a divorce or custody dispute or other legal proceedings, you need to understand and agree that I, as with most of the therapists at FYI, ***do not*** provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on three reasons: (1) My statements may be seen as biased in your favor because we have a therapeutic relationship; (2) the testimony may affect our therapeutic relationship, and (3) FYI therapists may not be trained as forensic experts. In the event, I am required by subpoena to appear in court for any reason, there will be a charge of $1,500.00 per 8-hour day with a minimum of $800 for a half day of 4-hours or less. A charge of $150 per hour will be collected for each hour over an eight (8) hour day. A non-refundable retainer of $6,000 must be paid in advance of any court-related work requested. **This includes tasks such as report preparation, meetings, interviews, in-court time, phone calls, case preparation, clerical work, file copies, conversations with a court appointed amicus or advocate, and any other tasks related to a court case, including, BUT NOT LIMITED, to divorce and custody cases.** The retainer must be paid before any work commences. Cash, cashier checks, PayPal,,Zelle, money orders, credit cards, debit cards, or other forms of payment with fund availability verification will be accepted. Because client appointments must be cancelled in advance, payment of fees will be applicable even in the event of court date postponement, rescheduled dates, case dismissal, negotiated settlements, or determination that my services are not needed. Court preparation and clerical time will be charged at a rate of $125.00 per hour to be deducted from the retainer. _____**(*Initial & date)***

10. **Emergencies** -- Our telephones are answered by confidential voice mail or our scheduling clerk when we are in session or out of the office**. In some cases, therapists have calls forwarded to their private numbers.** We will make every effort to return calls on the day received, with the exception of weekends and holidays. If you are unable to reach us and cannot wait for a return call, call 911, contact your family physician or go to the nearest emergency room. If we are unavailable for an extended time, a colleague will cover for us. _____**(*Initial & date)***

11. **Technology Use** -- FYI may use text, email, and/or computer automated systems to remind clients of appointments. FYI makes every effort to ensure client PHI (protected health information) and PI (personal information) are not revealed when using technology. **Email messages from FYI therapist contractors are to be sent via encrypted email services**. Texts should have no client identifying information in them. This includes, but is not limited to, client name, initials, address, phone number, FYI client account number, information alluding to a client and therapist relationship, and/or any other information that may identify the client or the nature of the client's business with FYI. Therapist contractors are cautioned not to use email and/or text as a form of therapeutic intervention and or conversation. Personal phones used for client business must have a screen lock to prevent unauthorized viewing of client content on the phone. Therapists are cautioned not to attach client names, FYI account numbers, initials or any other protected identifying information to client numbers in cell phones. To restate, when client phone numbers are stored in personal phones, information (including but not limited to client names and FYI account numbers) that may allow unauthorized persons to identify the client should not be linked to the client's contact information. Other persons (including but not limited to, children, family members, acquaintances, and/or friends) should not have access to use of the phone that contains any PHI, PI, or any HIPPA covered information on it. On a limited basis and in strict compliance with HIPPA guidelines, FYI may offer the option for phone sessions and/or computer video sessions for clients who are unable to schedule regular appointments in the office. FYI does require the intake session(s) to be held in person and does require face-to-face sessions in the office a minimum or each six (6) weeks. Confidentiality is maintained where possible, but clients using technology options are advised there may be occasions when outside forces may breach security

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systems in place. **Clients are cautioned that contract therapists and FYI cannot insure HIPPA confidentiality when cell phones are turned on in session; therefore, it is suggested all phones, iPads, and other electronic devices be turned off during therapy sessions.** Phone and video sessions may not be covered under insurance. _____***(Initial & date)***

12. **Counseling VIA Technology** - Technology-assisted distance counseling for individuals, couples, and groups involves the use of the telephone or the computer. Tele counseling involves synchronous distance interaction among counselors and clients using one-to-one or conferencing features of the telephone or computer to communicate. Video based individual Internet counseling involves synchronous distance interaction between counselor and client using what is seen and heard via video to communicate. To utilize technology for therapy, the client must meet the following guidelines:
    a. Be an established client with intake paperwork, payment information, credit or debit card information with permission to charge, and an emergency contact face sheet on file with FYI.
    b. Be prepared to definitively identify himself/herself as being the person to whom the therapist is speaking. This may include providing unique information such as social security number, predetermined code words, address, and/or other identifying information.
    c. Have a release of information for an emergency contact for a person at or with access to the location from which the client calls.
    d. Assume responsibility for securing a location that is confidential.
    e. Understand when communicating via technology, confidentiality cannot always be guaranteed.
    f. By engaging in counseling via technology, client acknowledges that risk and holds FYI harmless.
    g. Be domiciled (primary residence) in the state of Texas or be located on a US military base if out of the State of Texas to receive counseling services from FYI therapist contractors. Therapists are licensed to practice only in Texas.
    h. Agree to an alternate form of communication in case technology fails during the counseling session. If counseling cannot be resumed, client will still be charged for the session. If technology fails less than 30 minutes into a counseling session and communication cannot be reestablished, client can reschedule at no charge for the remainder of the missed session.
    i. Remember when visual cues (video) are unavailable, misunderstandings can occur.
    j. Your technology based sessions are not recorded or preserved in any way by FYI. Your counselor will take notes (as directed by law). _____ ***(Initial & date)***

13. **Facebook and Social Media** - Social media, including but not limited to Facebook, Twitter, Instagram and others may be used by therapists in this practice as tools for marketing services and disseminating information about themselves and the services they offer. Social media of any kind are not secure in terms of privacy and confidentiality, so the FYI policy regarding the use of social media includes the following:
    a. We do not provide therapy via social media.
    b. Ethical codes prohibit therapists from friending, following, or otherwise interacting with clients via social media.
    c. Therapist contractors will not acknowledge or return private messages delivered via social media.
    d. Therapist contractors will not acknowledge or respond to client emergencies delivered via social media.
    e. If you have an emergency do not contact your therapist via social media. Instead call the FYI office, go to the emergency room nearest you and/or call 911.
    f. You may use social media to reveal your own identity as a client of FYI, but you may not reveal the identity of another client. Doing so would be a breach of confidentiality, and FYI would take all available steps to protect the revealed client's rights, including blocking the offending client from accessing our social media and referring the offending client to another practice. _____ ***(Initial & date)***

14. **Therapist/Supervisor Scope of Competence** – I understand FYI therapist contractors maintain and will provide upon request detailed education and licensure information. I have been informed of my therapist's scope of competence, education, and licensure. _____***(Initial & date)***

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FAMILY AND YOUTH INSTITUTE LLC

Counseling and Psychotherapy - Client Services Agreement & Disclosure

SIGNATURE PAGE

Your signature below indicates you have read and fully understand the Family & Youth Institute, LLC Counseling and Psychotherapy - Client Services Agreement & Disclosure and agree to its terms. It also serves as an acknowledgement that the HIPPA privacy notice described above was made available to you.

_____ _____
Print Client Name ***Date***

_____ _____
Client Signature ***Date***

_____ _____
Signature of parent or guardian required for clients less than 18 years old. ***Date***

*****It is requested that parent or guardian AND minor client Age 17 sign the documents*****
*****Clients age 18 and older must sign documents themselves. To communicate information to parents regarding client sessions, clients will need to have a permissions to release information form on file.*****

COMPLAINTS:
A person who provides professional counseling services to clients must be licensed, unless exempted by State Law.
A consumer who wishes to file a complaint against an individual licensed by the Texas Licensure Board may call: 1-800-942-5540 or may visit the Website at www.dshs.state.tx.us/counselor or write to Texas State Board of Examiners of Professional Counselors, MC1982, P. O. Box 141369, Austin, TX 79714-1389.

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Consent To Treat – This form must be included in each minor client's file.

In order for minor children to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:
Name_____ Date of Birth____/_____/____
Name_____ Date of Birth____/_____/____
Name _____ Date of Birth____/_____/____
Relationship to child(ren) of person requesting services:
___Parent ___Stepparent ___Guardian ___Grandparent ___ Other_____

Yes____ No____ Are you the legal parent or custodian to above-named children?
If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you will be asked to provide a copy of the court order which names you the legal custodian of the above children. We must have the entire document and must be able to verify your right to consent independently to mental health care. Mental health care rights may differ from standard medical care rights.

Yes___ No___ N/A_____ I have provided/will provide proof, by court documents, that I have the legal right to request counseling or psycho-therapeutic treatment for the above minor.

If the answer to any of the above questions is "No," counseling services cannot be provided to the above named child(ren) until a copy of the court order naming you the legal custodian is provided to this office and/or a signed FYI Consent to Treat form is received from both parents.

I acknowledge that:

- *Both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).*
- *This treatment may also include referral to other appropriate State, Private, and/or County agencies for further counseling.*

I _____(Parent/Guardian), hereby give my consent for_____ (Child's Name) to receive counseling or psychotherapy by _____ (Therapist Name) of the Family &Youth Institute, LLC.

These services may include: (Check all that apply)

( ) Clinical Service ( ) Psychological Testing ( ) Counseling,
( ) Psycho-education ( ) Play Therapy ( ) other services_____.

_____ _____ Date__/___/____
Name of Client Signature
_____ _____ Date: __/___/____
Name of Parent/Guardian Signature if client is a minor

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Credit/Debit Card/ Checking Account Payment Authorization

Client Name: _____ **Responsible Party:**_____

I,_____ (Card Owner's Name) authorize Family & Youth Institute, LLC, to charge my sessions or copayments to my credit or debit card account as referenced below:

Payment Options: (Present your card for each session you want to charge.)
___ 1. Charge my account for **all** of my sessions/ co-payments as they occur.
___ 2. Charge my account **only when I do not pay by check or cash.**
___ 3. Charge my account for my **current balance due** in the amount of $_____.

NOTE: A fee of $80 WILL BE CHARGED TO YOUR CREDIT/DEBIT CARD ON FILE WITH US FOR ANY MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 BUSINESS HOURS PRIOR TO THE APPOINTMENT TIME.

Credit Card Account Information:

Credit Card#:_____ Exp. Date ____/____ CVC Code:_____ Zip Code: _____
___Discover ___Master Card ___Visa ___American Express Discover _____
_____Date:___/____/____
Signature of Authorized Credit Card Holder

***Debit Card Account Information:**

Debit Card#: _____ Exp. Date: ____/____ CVC Code:_____ Zip Code: _____
___Visa ___MasterCard ___Discover ___American Express Visa_____
_____Date: ____/____/____
Signature of Authorized Card Holder

**** Health Savings Account Information:**

HSA Card Number:_____ Exp. Date:____/____ CVC Code:_____ Zip Code:_____
___Visa __MasterCard ___Discover ___American Express Visa _____
_____Date: ____/____/____
Signature of Authorized Card Holder

In the event that I have not paid on my account within 90 days after services have been rendered, I agree to allow Family & Youth Institute, LLC to charge my account for the balance due. I also agree to allow Family & Youth Institute, LLC to charge an $80 fee for any missed appointments that do not follow cancellation guidelines provided in the FYI disclosure

_____ **Date: ____/____/____**
Signature of Authorized Card Holder

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CLIENT INFORMATION FORM

Date Open: _____Closed: _____

CLIENT INFORMATION

Client Name _____ DOB _____/_____/_____
Gender: M_____ F _____
Client Address _____ City: _____ St: _____ Zip _____
Home Phone_____Cell _____ Email_____
Client Employer/School_____ Employer/School Phone _____
Client TEXAS DRIVER'S LICENSE NO. _____**Client SS#:**_____

PARENT/GUARDIAN INFORMATION

If a client is a minor please provide parents' names, addresses, dates of birth, and phone numbers.

Mother's Name: _____D.O.B._____ Phone: _____
Address: _____City:_____State:_____Zip:_____
Mother's SS#: _____Work Phone _____ Mobile Phone _____

Father's Name: _____D.O.B._____ Phone: _____
Address_____City:_____State:_____Zip:_____
Father's SS#: _____Work Phone _____ Mobile Phone _____--_____

IF OTHER THAN PARENT: Financial Guarantor Name:_____
Guarantor Address _____ City: _____State: _____ Zip _____
Guarantor Employer _____Phone _____

Guarantor Driver License: _____DOB:----------DL #:_____
_Name:_____Address:_____ Phone: _____

Nearest Relative Not Living i with you: _____Relationship: _____
Address: _____Phone: _____

Name of nearest Friend Not Living With You: _____
Address:_____ Phone:_____

Who Referred You: _____Phone: _____

I understand and agree that I am ultimately responsible for the balance on my account for all services rendered. I have completed the above answers and certify this information is true and correct to the best of my knowledge. I agree to notify you of any changes in status for the above information.

Signature of Client _____ Date____/____/___

Signature of Parent/Guardian/Guarantor_____ Date ____/____/___

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INSURANCE BENEFITS VERIFICATION FORM

This form must be thoroughly completed. We will be unable to file your insurance claims without this information and you will be financially responsible for the full amount of each session.

CLIENT INFORMATION

Client Name: _____ DOB: ___/___/__ Gender: _____M____ F____
Client's relationship to insured: _____Self _____ Child ____Spouse _____Other:_____
Client's Contact: Home Phone: ____ _____Cell Phone: _____
Client/'Email: _____Client Fax:_____
Client's Employer/School _____Phone: __ _____

INSURED INFORMATION

Insured's Name _____ Home Phone: (_____)_____
Insured's DOB: _____/_____/_____ Insured Address:_____
Insured's Employer _____ Office Phone: (___ __)_____
Group#: _____ SS#:_____ INS. ID#: _____
Insurance Co. Name: _____ Insurance Type: ☐HMO ☐PPO ☐EAP ☐_____
Phone No. for Mental/Nervous or Member Services: (_____) _____ - _____
Secondary Carrier: _____ Phone No.: (_____)_____
Group#_____ SS#:_____ INS. ID#: _____

Complete only if you have called your insurance company for the information requested below:

Have you made the initial call to your insurance company prior to your first session to inquire about pre-authorization of benefits? Y / N

Pre-certify: ☐ **yes** ☐ **no** **Phone: _____ Authorization # _____**
Coverager Start Date: _____ Expiration Date: _____
Deductible: _____ Met? Y / N Remaining $: _____Co-pay $: _____
Total sessions per calendar year: _____No. Sessions Remaining: _____

I hereby authorize release of information necessary to file a claim with my insurance company to Family & Youth Institute, LLC, and ASSIGN BENEFITS OTHERWISE PAYABLE TO Family & Youth Institute. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

SIGNATURE: _____ Date:_____/_____/____

Signature of Patient or Guardian/Policy Holder

I hereby authorize my therapist/counselor to release any information acquired in the course of my examination or treatment necessary to satisfy mental health insurance claims. I realize that my insurance carriers may require detailed personal information about my psychotherapy in order to certify and/or authorize payment for my sessions.

Client Signature _____ Date _____/_____/_____
Parent/Guardian Signature_____ Date _____/_____/_____
Insured's Signature _____ Date _____/_____/_____

Family &
Youth Institute, LLC

25511 Budde Rd., Marimed Bldg., 401-402
Spring/The Woodlands, TX 77380
Phone: 281-748-0233
*Email: **familyyouth1@hushmail.com***
http://familyandyouthinstitute.com

CLIENT NAME:_____**: DOB:** _____**APPT. DATE:** _____ **TIME:**_____
THERAPIST NAME:_____ **THERAPIST SIGNATURE:**_____

Certification of Sessions

You are responsible for verifying benefits, **obtaining referrals from primary care physicians and pre-certifying your sessions unless we are contracted as a provider from your insurance company.** Failure to contact your insurance company for pre-authorization usually results in a denial of payment. In this case we must hold you financially responsible for the full amount due for all services performed. _____ (Initial and date)

Financial Responsibility

Ultimately, **you are responsible for the total amount due including any amount not covered by your insurance company except when covered by insurance companies with whom we are a contracted network provider.** Please understand, your insurance company does not guarantee payment of any claim we submit.

I accept full financial responsibility for my account as described above with Family & Youth Institute. I also understand and agree that charges to my account will be subjected to a late charge of 1.5% per month on any unpaid balance. I agree to pay for any $5.400 per check for returned checks.

_____ Date: _____/_____/_____

Signature of Responsible Party

Filing Insurance Claims

Request to File Benefits -- It is my request that the **Family & Youth Institute** file charges with my insurance company and **I agree to pay any and all deductible and co-payments at the time services are rendered.**

_____ Date: _____/_____/_____

Signature of Responsible Party

Assignment of Benefits

We will accept assignment of benefits under the following conditions: (1) deductibles and co-payments are paid at the time services are rendered or within 30 days of receiving a bill and (2) **completed and signed intake forms are provided to our office by the patient in a timely manner**. Please note that insurance companies have time limits on the amount of time we are allowed to submit a claim. _____ (Initial and date)

I agree to assign my benefits to the Family and Youth Institute.

_____ Date: _____/_____/_____

Signature of Responsible Party

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CLIENT NAME:_____**: DOB:** _____**APPT. DATE:** _____ **TIME:**_____
THERAPIST NAME:_____ **THERAPIST SIGNATURE:**_____

Consent to Release of Information/Records

THIS IS TO BE COMPLETED FOR ANY PERSON WHO HAS PERMISSION TO RECEIVE OR DISCUSS YOUR OR YOUR MINOR CHILD'S THERAPEUTIC INFORMATION.

FOR MINOR CLIENTS THIS FORM IS COMPLETED FOR ANY PERSON WHO IS NOT A LEGAL GUARDIAN OR BIOLOGICAL PARENT IF THAT PERSON WILL BE RECEIVING CLIENT INFORMATION OR PARTICIPATING IN CLIENT SESSIONS. THIS INCLUDES STEP-PARENTS, CHILD CARE PROVIDERS, GRANDPARENTS, AND OTHRR.

I _____hereby authorize_____ to release information
(Client/ Parent / Guardian's Name) (Physician/School/ Non-biological Parent/Guardian)
to _____ concerning confidential information pertaining to me (or my minor child).
(Clinician at FYI)

****

I _____hereby authorize_____ to release confidential
(Client/Parent/ Guardian 's Name) (Clinician at FYI)
confidential information pertaining to me (or my minor child) to_____.
(Physician/School/ Non-biological Parent/Guardian)

In consideration of this consent, I hereby release the above parties from any legal liability the release of this information.

NAME: _____DOB: _____ SSN: _____

Release shall be limited to following:

☐Psychiatric/Medical ☐Psychological
☐Progress Notes ☐Vocational ☐Educational
☐Drug/Alcohol Abuse ☐Unrestricted ☐Diagnosis
☐Other –
Specify_____

Release of the above information is required for the following purpose:

☐Update Psychological ☐Review of Prior Treatment
☐Monitor Medical Status ☐Medication Verification
☐Use In Residential Placement ☐ Other – Specify_____

I understand this consent is subject to revocation at any time, except to the extent that action has been taken . In any event, this consent shall expire one (1) year from the date signed unless revoked earlier. _____(initial) ____/____/___(date)

_____ _____ ____/_____/_____
Client Signature Parent/ Guardian Signature Date

TO THE PARTY RECEIVING THIS INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. Where a drug and alcohol abuse client is involved, Federal law also protects the confidentiality of these records. See, 42 CFR, Part 2. In either event, information shared is subject to the applicable laws, rules, and to whom it pertains, or as otherwise permitted by the applicable laws, rules and regulations. Please note: A general authorization for the release of medical or other information is not sufficient for these purposes. Regulations prohibit you from making further disclosure of these records without the specific written consent of the person.

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CLIENT NAME:_____**: DOB:** _____**APPT. DATE:** _____ **TIME:**_____
THERAPIST NAME:_____ **THERAPIST SIGNATURE:**_____

FOR PRIMARY CARE PHYSICIAN INFORMATION ONLY

Circle name(s) of Family & Youth Institute LLC therapist(s) transmitting this continuity of care information.

Mary Ann Sartori, M.A., LPC-S, CSC
President

Interns

Lisa Domengeaux, M.Ed., LPC-Intern, CSC

Lauren Mills, M.A., LPC-Intern

Sarah Stewart, Master's Level Student Intern

Chad Odom, M.S., LPC-Intern
Supervisor: Andres Tapia, Ph.D., LPC-S

Mikayla Williams, M.A., LPC-Intern
Megan Garzaglass, M.S., LPC-S

THERAPISTS

Ariel Batton, M.A., LPC
EMDR Trained

Mary Margaret Bollato, M.Ed., LPC, CSC

Fergie Havemann, M.A., CCATP

Laura Henderson, M.Ed., LPC. CSC

Connie Hoagland, M.Ed., LPC, CSC

Amanda Norminton, M.A, LPC, LMFT

Jessica Talamantez Garza, M.A., LPC

To: Primary Care Provider
FROM: FAMILY & YOUTH INSTITUTE LLC
RE: CONSENT FOR FAMLY & YOUTH INSTITUTE TO RELEASE CLIENT CONTINUITY OF CARE INFORMATION TO PCP

The following client is being treated by a therapist in this office for the following condition:

Client:_____ DOB:_____

DX: _____

Authorization expires on (date) _____

I hereby request and authorize Family & Youth Institute LLC therapist [name(s) designated/circled on the left] to communicate this continuity of care information to the Primary Care Physician listed below:

YES_____ NO_____

THIS IS NOT A REQUEST FOR RECORDS. PER INSURANCE REQUIREMENT, THIS IS A CONTINUITY OF CARE COMMUNICATION TO YOU THAT THIS CLIENT IS BEING SEEN IN THIS OFFICE.

Primary Care Physician Name:_____

Address: _____

City/State/Zip:_____

Phone Number:_____ FAX:_____

Email:_____

*Disclosure may include records that have information regarding diagnosis and treatment of psychiatric disorders but is/are not limited to these areas. To the party receiving this information: This information has been disclosed to you from records for which the confidentiality may be protected by Federal law. If so, Federal regulations (42CFR, Part 2) prohibit you from any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____
Adult Client Printed Name Adult Client/Signature

_____ _____
Patient/Guardian Printed Name Patient/Guardian Signature

_____ _____
Patient/Guardian Printed Name Parent\Guardian Signature

Date:_____ Date: _____