Counseling Center of Montgomery County

212 Conroe Drive
Conroe, TX 77301

www.CounselingCenterMC.com

CCMC@CounselingCenterMoCo.com

(936) 760-1880 Office
(936) 760-2915 Office
(936) 760-9101 Fax

CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Required Documents: __Insurance Card __Driver's License
__Minor's Birth Certificate __Minor's Proof of Guardianship
__Court Order (if court ordered for services)

Date of Assessment:_____

IDENTIFYING INFORMTATION

Name of Child:_____ Sex: Male / Female

Birth date: _____Age:_____ Place of Birth: _____

Address: _ _____

City/State_____ Zip:_____

Home Telephone Number: _____ Cell Phone:_____

Current School/Teacher: _____

Family Information

Mother's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Employer: _____Position:_____

Father's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Employer: _____Position:_____

Step-Mother's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Employer: _____Position:_____

Step-Father's Name:_____ D.O.B.:_____ Age:_____

Address :_____

City:_____ State:_____ Zip:_____

Home Telephone Phone: _____ Cell Phone:_____

Work Phone: _____ Email: _____

Employer: _____Position:_____

Parent/Guardian/Representative Signature: _____ Date: _____

Current Concerns:

Why are you seeking counseling for your child?

How long have these problems occurred?

Problems perceived to be (Please circle):
Very serious Serious Not serious

What happened that makes you seek help at this time?

What changes would you like to see in your child?

What changes would you like to see in you?

What changes would you like to see in your family?

Has the child ever seen a therapist/psychologist/counselor before? Please explain:

Current Family situation:

Who currently resides in the home with the child?

Marital history of the biological parents:
Married Separated Deceased Divorced Never Married

Does the child have a step-mother? Yes No
How long has the step-mother been in the child's life? _____
Describe the child's relationship with the step-mother:

Does the child have a step-father? Yes No
How long has the step-father been in the child's life? _____

Describe the child's relationship with the step-father:

If the child is adopted:

Age when child came into the home: _____ Date of legal adoption: _____

Reason and circumstance for adoption:

When was the child told?

What has the child been told?

Name of brother / sister	Age	How related? Full / Half / Step / Other	Relationship? Good / Fair / Discord

Please list where the child has resided and with whom throughout his/her life:

Was the child ever placed, boarded, or lived away from the family? Yes No

Explain:

What are the major family stressors at the present time, if any?

HEALTH OF THE FAMILY MEMBERS:
List all the family members by their relation to the client who have a history of depression, ADHD, anxiety, mood disorder, drug/alcohol abuse, behavioral problems, legal problems, or other psychological problems:

Name:	Relation:	Mental Health:	Drugs / Alcohol:	Legal:	Other:

*Please list addition family members on the back of this page

CHILD HEALTH INFORMATION:
Note all health problems the child has had or has now:

Age		Age		Age	
	High Fever		Dental Problems		Pneumonia
	Weight Problems		Flu		Allergies
	Encephalitis		Meningitis		Convulsions
	Unconsciousness		Concussions		Head Injury
	Fainting		Dizziness		Tonsils Out
	Vision Problems		Hearing Problems		Earaches
	Skin Problems		Asthma		Headaches
	Stomach Problems		Accident Prone		Anemia
	High Blood Pressure		Low Blood Pressure		Sinus Problems
	Heart Problems		Hyperactivity		STD
	Infectious Disease		Other Illnesses		

Please Explain: _____

_____

_____

Has the child ever been admitted to a psychiatric hospital? Yes No
If yes, please explain:

Age Admitted:	How Long:	Reason / Diagnosis:	Recommendations / Medications:

*Please list additional information on the back of this page

Has the child ever seen a medical specialist? Yes No
If yes, please explain:

Age:	How Long:	Reason / Diagnosis:	Recommendations / Medications:

*Please list additional information on the back of this page

Has the child ever taken or is he/she taking any prescribed medications? Yes No
If yes, please explain:

Age:	Medication:	Dosage / When taken:	Reason for Medication:	How long:

*Please list additional information on the back of this page

Name of Primary Care Physician(s) Phone Number(s) Address

DEVELOPMENTAL HISTORY:

Prenatal: Child wanted? _____ Yes _____ No
Planned for: _____ Yes _____ No
Normal Pregnancy _____ Yes _____ No
Length of Pregnancy: _____

If mother was ill, upset, diabetes, explain:

BIRTH:

Length of Labor: Easy Normal Difficult
Birth Weight _____ Length: _____
Type of Delivery: Spontaneous Cesarean With instruments Head First Breech
Was it Necessary to give the infant oxygen? YES NO
Explain:

Did infant require blood transfusion? Yes No
Explain:

Did infant require X-ray? Yes No
Explain:

Did mother abuse alcohol / drugs during pregnancy? Yes No
Explain:

NEWBORN PERIOD:

Irritability	Yes	No	How Long? _____
Vomiting	Yes	No	How Long? _____
Difficulty Breathing	Yes	No	How Long? _____
Difficulty Sleeping	Yes	No	How Long? _____
Convulsions/Twitching	Yes	No	How Long? _____
Colic	Yes	No	How Long? _____
Normal Weight Gain	Yes	No	How Long? _____
Breast Fed	Yes	No	How Long? _____

DEVELOPMENTAL MILESTONES:

Age at which child:

Sat up _____ Crawled _____
Walked _____ Spoke single word _____
Bladder trained _____ Bowel trained _____
Weaned _____ Spoke sentence _____

EARLY SOCIAL DEVELOPMENT:

Describe the child's interaction with siblings and peers:

Describe the child's special habits, fears, or idiosyncrasies:

EDUCATIONAL HISTORY:

Name of School	Dates Attended	City/State	Grades Completed

Is the child enrolled in any special education or specially modified classes? _____ Yes _____ No
Explain:

Has the child ever been retained or skipped a grade? _____ Yes _____ No
Explain:

Does the child attend school on a regular basis? _____ Yes _____ No
Does the child appear motivated for school? _____ Yes _____ No
What are the child's grades?

What is the child's favorite class?

Least favorite class?

Has the child been suspended or expelled? _____ Yes _____ No
Explain:

Does the child participate in extracurricular activities? _____ Yes _____ No
Explain:

How many friends does the child have in school / in neighborhood?

What are the child's educational aspirations?

LEGAL HISOTRY:

Has the child ever had difficulty with police? Explain:

Has the child ever appeared in juvenile court? Explain:

Has the child ever been on probation? Explain:

Does the child use alcohol, tobacco, other drugs, or abuse prescription medication? Explain:

Has the child been forced to participate in substance abuse classes, tobacco cessation classes, anger management, or other classes per court order? Explain:

EMPLOYMENT:

Has the child ever been employed? _____ Yes _____ No

Employer:	When:	Length of Employment:	Reason for Leaving:

OTHER INFORMATION:

What are the child's hobbies and interests?

What are the child's strengths and talents?

What religion is the child?

Does he/she attend church regularly?

What cultural affiliation does the child have?

Additional Comments:

Parent Signature Date

Therapist Signature Date

Child Checklist of Characteristics

Name **Date**

Please review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

____ Affectionate
____ Argues, "talks back", smart-alecky, defiant
____ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
____ Cheats
____ Cruel to animals
____ Concern for others
____ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
____ Complains
____ Cries easily, feelings are easily hurt
____ Dawdles, procrastinates, wastes time
____ Difficulties with parent's paramour/new marriage/new family dependent, immature
____ Developmental delays
____ Disrupts family activities
____ Distractible, inattentive, poor concentration, daydreams, slow to respond
____ Dropping out of school
____ Drugs or alcohol use
____ Eating-poor manners, refuses, appetite increase or decrease, odd combinations, overeats
____ Exercise problems
____ Extracurricular activities interfere with academics
____ Failure in school
____ Fearful
____ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
____ Fire setting
____ Friends, outgoing, social
____ Hypochondriac, always complains of feeling sick
____ Immature, "clowns around", has only younger playmates
____ Imaginary playmates, fantasy
____ Independent
____ Interrupts, talks out, yells
____ Lacks organizational, unprepared
____ Lacks respect for authority, insults, dares, provokes, manipulates
____ Learning disability
____ Legal difficulties- truancy, loitering, panhandling, drinking, vandalism, stealing, fight, drugs sales
____ Likes to be alone, withdraws, isolates
____ Lying
____ Low frustration tolerance, irritability
____ Mental retardation
____ Moody
____ Mute, refuse to speak
____ Nail biting
____ Nervous
____ Nightmares
____ Need for high degree of supervision at home over play/chores/schedule
____ Obedient
____ Obesity

____ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
____ Oppositional, resists, does not comply, negativism
____ Prejudiced, bigoted, insulting, name calling, intolerant
____ Pouts
____ Recent move, new school, loss of friends
____ Relationships with brothers/sisters or friends/peers are poor competition, fight, teasing/provoking, assaults
____ Responsible
____ Rocking or other repetitive movements
____ Runs away
____ Sad, unhappy
____ Self-harming behaviors-biting or hitting self, head banging, scratching self
____ Speech difficulties
____ Sexual-sexual preoccupation, public masturbation, inappropriate sexual behaviors
____ Shy, timid
____ Stubborn
____ Suicide talk or attempt
____ Swearing, blasphemes, bathroom language, foul language
____ Temper tantrums, rages
____ Thumb sucking, finger sucking, hair chewing
____ Tics-involuntary rapid movements, noises, or word productions
____ Teased, picked on, victimized, bullied
____ Truant, school avoiding
____ Underactive, slow-moving or slow-responding, lethargic
____ Uncoordinated, accident prone
____ Wetting or soiling the bed or clothes
____ Work problems, unemployment, workaholic/overworking, can't keep a job

Any other characteristics:

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?

Parent Signature Date

Therapist Signature Date

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CONSENT TO SERVICES / RIGHTS ACKNOWLEDGEMENT

CONSENT TO SERVICES

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary by Counseling Center of Montgomery County, hereafter referred to as the clinic. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive at this clinic are not rendered, then the clinic may stop my treatment.

I understand and have been informed that Licensed Professional Counselor – Interns may be involved with my treatment and sessions.

I have been informed that any information regarding services at Counseling Center of Montgomery County are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

_____ Initials

CONSENT FOR TREATMENT OF MINOR

I authorize this clinic to provide services for _____. I agree to follow-up with phone conversations regarding progress in therapy and to participate in therapy as recommended.

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BASIC RIGHTS

1. You have the right to impartial access to treatment regardless of race, religion, sex, age ethnicity, or handicap.
2. You have the right to considerate and respectful treatment and recognition of your personal dignity.
3. You have the right to a written statement of your rights.
4. You have the right to be informed of your rights in a language you understand.
5. You have the right to adequate and humane services regardless of financial support.
6. You have the right to services provided in the least restrictive environment possible.
7. You have the right to participate in treatment decisions.
8. You have the right to obtain information about treatment recommendations and alternatives.
9. You have the right to obtain information about your condition and prognosis from your clinician.
10. You have the right to be told about any medications you are given.
11. You have the right to an adequate number of qualified, professional clinicians to actively supervise and implement services with patients under 12 years of age, and their parents or guardians.
12. You have the right to periodic review of your treatment plan.
13. You have the right to be involved in planning termination of your treatment.
14. You may terminate services at any time unless legally prohibited from doing so.
15. You have the right to be informed of alternatives available when you leave treatment, and you will be given specific follow-up recommendations outlined.
16. You have the right to report any incidences of abuse or neglect, whether you are a victim or an observer.
17. You have the right to expect that all communications and report records pertaining to your treatment will be treated as confidential, except as otherwise required by law.
18. You have the right to be told of any experiment treatment approach recommended for you, and you must give your written informed consent before any such approach may be used.
19. Patients, significant others, and staff have the right to have ethical issues that arise in treatment considered.
20. You, your family, or legal guardians, have the right to present complaints concerning the quality of care received.
21. You and your family / significant others have the right to request a review of the practices and procedures for insuring patients' rights and for addressing questions or complaints about your individual treatment plan.
22. You have the right to be told in advance of all estimated charges being made, the costs of services provided, sources of the clinics' reimbursement, and any limitations on length of services known.
23. You have the right to withdraw your permission at any time in matters to which you have previously consented.
24. You have the right not to be given medications you do not need or too much medication, including the right to refuse medications unless your condition or behavior places you in immediate danger.
25. You have the right to request the opinion of another clinician at your own expense.

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOU YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclosed, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of Licensed Professional Counselor Interns, and licensing. For example, we may call you by a name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by lay.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the

restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

III. Complaints

You may file any complaints with our office staff, at 936-444-3546, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

I, _____, have read and understand the information contained in the HIPAA Notice of Privacy Practices form.

_____
Initials

Please acknowledge your receipt of this Notice of Privacy Practices by signing below.

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Parent or Representative Signature (relationship) Date

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CANCELLATION POLICY

We look forward to working with you. Our appointment sessions are approximately forty-five (45) minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no show fees, we require at least twenty-four (24) hours notice for all cancellations, unless your appointment is on Monday, at which we cancellation needs to be before 3pm on the prior THURSDAY. Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the $50 fee for a missed appointment at the first no show or late cancellation. After the second no show or late cancellation, you are responsible for the entire fee of $120 to $150 and to continue scheduling, you will have to pre-pay the third session at $120 to $150.

After 3 cancellations or no shows, you will not be able to schedule another appointment and will be referred to another provider. If you have arranged with your therapist to have standing appointments, then after the first no show, all appointments will be removed from the schedule and will have to arrange appointments weekly.

I have read and understand the cancelation policy.

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CASE MANAGEMENT FEES

Court Testimony and Related Expenses:
I understand that Counseling Center of Montgomery County is available to testify in court concerning the therapeutic work with _____.
I also understand that the court appearance fee is $200 per hour, and that any parking and toll fees incurred will need to be paid (per receipts), in addition to these costs. I understand that to reserve Counseling Center of Montgomery County for court testimony, they require a minimum pre-payment of 3 hours, or $600 due prior to the court date and is nonrefundable. Should the 3 hour reservation be exceeded, then I agree to pay the additional costs of $200 per additional hour at the time of the hearing.

_____
Initials

Copy of Client Record:
Preparation of client record must have a judge's order for release of HIPAA and the fee is $125.00 per hour. Copies of files prepared by our office are charged at $.50 per page, plus the hourly time ($125.00/hour). If an affidavit is requested, certifying that the information is a true and correct copy of the records, a fee of $15 will be charged for executing the affidavit. These fees must be paid prior to receiving the documents.

_____
Initials

Reports:
Preparation of written reports for the courts, attorneys, or other legal staff is $250.00 and requires a written consent. These fees must be paid and documents signed prior to releasing the report.

_____
Initials

Correspondence and Case Review Outside of Scheduled Sessions:
If collateral correspondence or case review is required for your case outside of your scheduled appointment, then you will be billed at 15 minute increments for $50 per unit. This is work that is not covered by your insurance. You have the option of creating an account that will allow these duties to be performed promptly or you can pre-pay as the tasks are presented. Please understand that before the tasks are completed, payment will be required. If you choose to create an account, then any funds that remain will be reimbursed at the close of treatment.

_____
Initials

I have read and fully understand the information contained in this document and the fees associated with services that are not covered by insurance. I agree to pay the fees for the therapist or a CCMC employee if I request these services.

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Notice of Recordings

Counseling psychotherapy sessions are routinely audiotaped in many treatment and training settings, but counselors must obtain a client's permission prior to turning on any recording device. We have the highest regard for the safety of our clients and their confidentiality and will not proceed in recording any session without your prior knowledge and consent.

In addition, we do not consent to clients recording any session during the time of treatment. If you would like to have your session recorded, please address the issue with your therapist and make arrangements.

I, _____, assert that I will not record my therapy sessions during treatment. I also understand that my therapist will inform me of a session being recorded and will obtain written consent prior to recording a session. I understand that I have the right to deny any audio or video recording and I have the right to revoke any prior consent for an audio or video recording.

I have read and fully understand the information contained in this document.

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Financial Policy

Thank you for choosing Counseling Center of Montgomery County. Please carefully review our financial policy. Our business office is available to answer any questions you may have regarding our financial policy or your payment responsibilities. They can be reached at 936-760-1880.

INSURANCE SERVICES

Counseling Center of Montgomery County, hereafter referred to as the clinic, participates with many health plans. AS A COURTESY TO OUR CLIENTS, we will file claims with these companies; however, it is ultimately your responsibility for the full and timely payment of your account.

Please be prepared to submit your current insurance card at each visit. A scanned copy of this card may be kept as part of your permanent record. Please also provide the clinic with up to date contact information including your home address, telephone number, and emergency contact information.

The clinic will attempt to verify coverage and benefits prior to your visit with the psychotherapist. If we are unable to obtain a verification of coverage you will be asked to pay in full or reschedule your visit at a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment.

Please be aware that certain diagnoses may not be covered or may be considered “not medically necessary” by your health plan. You are responsible for payment of these services. Please also be aware that many health plans limit annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. The clinic will provide care base on the client’s needs, not a client’s insurance coverage. Your psychotherapist is not responsible for knowing your plan’s specific benefit and coverage limitations.

FAILURE TO CANCEL APPOINTMENTS / NO SHOWS

The clinic will charge a $50.00 fee for failure to arrive at scheduled appointments. In order to cancel an appointment you must call 24 hours in advance to allow time for our office to fill that appointment time. Failure to give 24 hour notice on a cancelled appointment will still incur a $50 charge.
NOTICE: Medicaid clients that No Show will also be reported to the fraud and abuse line @ 800-447-8477.

PAST DUE ACCOUNTS

If your account becomes past due we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed from treatment at Counseling Center of Montgomery County. In addition, there is a 1% per month (12% APR) interest charge on all accounts that are not paid within 60 days of the billing date. A

representative in our business office is available to answer any questions you may have regarding your account or set up payment arrangements. They can be reached at 936-760-1880 and they are available Monday – Thursday 9am to 4pm.

NSF CHECKS

If a check is returned for insufficient funds, account closed, or payment is stopped, your account will be charged a $35.oo fee. In the event that this happens, you will be required to pay cash for future visits.

COPAYS

All copays are due at the time services are rendered. If unable to pay your copay, please contact the business office BEFORE your appointment to make arrangements.

MEDICAID PATIENTS

Please be prepared to submit your current Medicaid card at EACH visit. A scanned copy of this card may be kept as part of your permanent record. As failure to provide a current card, the clinic will attempt to verify coverage. If we are unable to obtain a verification of coverage you will be asked to pay in full or reschedule your visit at a time the verification can be obtained. Please be aware that verifying coverage may take time that could delay your appointment.

APPOINTMENTS

Due to the high volume of appointments being made, please schedule your follow-up appointment before leaving our office. This is the only guarantee you will get an appointment as the therapist has recommended. Waiting to schedule your appointment may result in a long delay between sessions.

I acknowledge receipt of Counseling Center of Montgomery County's policies and I certify that I understand these policies.

Signature of Client	Date
Client's Name	
Name of responsible party if client is a minor	Relationship
Signature Parent / Legal Representative	Date

Counseling Center of Montgomery County

212 Conroe Drive
Conroe, TX 77301

www.CounselingCenterMC.com

CCMC@CounselingCenterMoCo.com

(936) 760-1880 Office
(936) 760-2915 Office
(936) 760-9101 Fax

PAYMENT CONTRACT FOR SERVICES

Name(s): _____

Address: _____ City, State, Zip: _____

Bill to (person responsible for payment of account): _____

Address: _____ City, State, Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay Counseling Center of Montgomery County, hereafter referred to as the clinic, a rate of $ 175 for the initial and $120 per individual / $150 per couples or family follow-up clinical unit (defined as 45 – 50 minutes for assessment, testing, and individual, family and relationship counseling).

A fee of $ 50 is charged for group counseling.

A fee of $ 50 is charged for missed appointments or cancellations with less than 24 hours' notice.

A fee of $ 250 is charged for a report.

A fee of $1500 is charged for a mental health evaluation.

Please refer to *"Court Testimony and Expenses"* for fees associated with court, attorneys, copy of client chart, and reports.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance that your policy contains (but is not limited to) the following provisions for mental health services:

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment _____ (circle one) Unlimited **OR** _____ # of visits allowed per year.
    a. If I exceed my allowable amount I understand my fees will be in accordance with cash pay rates.
3) Policy term date: _____

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in **Part One** above.

It is the client's responsibility to inform this clinic of insurance coverage and failure to do so will result in the client assuming responsibility for rendering payment for professional services received in accordance with **Part One**. This clinic will begin billing insurance upon receiving and verifying insurance coverage. Although this clinic will make every attempt to recover payment from insurance, any outstanding balance that is not reimbursed by the insurance, is the client's responsibility.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date. I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/____

Release of Information Authorization to Third Party

I (we) authorize Counseling Center of Montgomery County to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Counseling Center of Montgomery County.
I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Signature of Client	Date
Client's Name	
Name of responsible party if client is a minor	Relationship
Signature Parent / Legal Representative	Date

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CONTACTING YOUR THERAPIST

If there is an immediate life threatening emergency, please call 911 or go to your nearest emergency room. While Counseling Center of Montgomery County will do their best to assist you outside of a therapy session, we are not a crisis center.

You may also contact TriCounty MHMR 24 hour crisis hotline at 1-800-659-6994. For other assistance, you may contact Montgomery County United Way at 1-888-825-9682 or 1-888-844-6289.

For questions or concerns with a situation outside of the therapy session or to report relevant information to a case, you may email Counseling Center of Montgomery County at therapy.appointments@gmail.com or schedule an urgent appointment at 936-444-3546. Due to liability reasons and no insurance reimbursement, Counseling Center of Montgomery County does not accept phone calls in lieu of therapy sessions. Counseling Center of Montgomery County will respond accordingly to brief emails, but in order to seek services, discuss issues, or obtain a full response, you must schedule an appointment.

If you need to cancel, reschedule, or schedule an appointment, please contact the office at 936-760-1880 for assistance.

Client Signature Date

Parent or Representative Signature Date