

America's Family Counseling Center

1716 Briarcrest Drive, #305
Bryan, Texas 77802

How did you hear about America's Family Counseling Center?

___ Drive By ___ Signs ___ Friends ___ Internet ___ Other _____

CLIENT SERVICE AGREEMENT

Effective: August 1, 2016

Welcome to America's Family Counseling Center. This document (the agreement) contains important information about America's Family Counseling professional services and business policies. The law requires that we obtain your signature acknowledging that America's Family Counseling has provided you with this information. Your therapist can discuss any questions you have about the procedures during your session.

When you sign this document, it will represent an agreement between your therapist and you. You may revoke this agreement in writing at any time. The revocation will be binding on America's Family Counseling unless we have taken action in reliance on it; if there are obligations imposed on America's Family Counseling or if you still have any financial obligations to this office.

Overview of Therapy

At America's Family Counseling Center we are trained in a broad range of therapeutic techniques. We are not medical doctors and do not prescribe medications. Some potential benefits of therapy are handling emotions and relationships better, finding solutions for your problems, and reducing some of the symptoms that bring you in. The main risks of therapy involve exploring difficult or distressing thoughts, feelings and memories. The initial session or two will involve gathering information, discussing your diagnosis, and developing a treatment plan with your therapist. Regular therapy sessions are 45 minutes. During the initial session it will be discussed how often you should come in for visits.

To be successful in therapy, you will have to work on your goals both in session and at home. Your therapist will help you, but there is no guarantee that you will reach the goals you set. Your therapist will discuss other treatment options if he/she does not think that they can help you. Feel free to discuss any concerns you have about therapy, the treatment plan, your progress, etc. If your therapist does anything that is upsetting to you, it is important that together, you and your therapist discuss it. Your participation in therapy is voluntary (unless court- ordered) and you may stop therapy whenever you wish. Though not required, we recommend an orderly end of therapy for positive effect for you (the client). A final closure session has proved to be very important for clients, to help acknowledge and summarize what has been accomplished and discuss any unfinished concerns.

Initial here: _____

Confidentiality

The **HIPPA regulations** discussed in the Notice more fully cover **confidentiality**. To summarize that information, with your consent on this Agreement Form, I may share your personal health information (PHI) with your insurance company, and with business professionals whom we use such as our computer system company or our answering service. All of these people are bound by the same confidentiality requirements under HIPPA. When we release information, we release the minimum information necessary. Any other release of PHI outside of this office requires that you complete a signed Authorization form that has specific HIPPA- required information.

I will try to discuss any disclosures that you have not authorized with you before they occur. Laws on confidentiality are complex and may change. Our office is required to follow all applicable state and federal laws.

Initial here: _____

Client Rights

HIPPA provides you with several new rights concerning your clinical record and the disclosure of your Personal Health Information (PHI). You have been given notification of all Health Insurance Portability & Accountability Act (HIPPA) requirements concerning privacy policies. You understand that this information will be used to: conduct, plan and direct your treatment and follow-up care, obtain payment (complete insurance reimbursement forms), conduct normal health care operations such as quality assessments and physician certifications.

You may request in writing how your private health information (PHI) is used or disclosed to carry out treatment, payment or health care operations. You also understand we are not required to agree to your requested restrictions, but if we do agree, then we are bound to abide by such restrictions.
Talk to your counselor if you have any confidentiality concerns.

Initial here _____

Informed Consent for Telephone, Electronic, and Mail Contact

Many individuals feel comfortable communicating via email, because they have installed programs designed to detect spy ware, viruses, or other dangerous software. Even if these programs are used there is no guarantee that such programs will work 100%. Sent and received emails are stored on both America's Family Counseling and whichever computer you use.

By initialing bellow, you (the client) understands the risk with regards to communicating via e-mail with America's Family Counseling Center and accept the risks that may be present with such communication.

Initial below if you give permission for America's Family Counseling to initiate sending text messages, emails including, email reminders of upcoming appointments. I also authorize America's Family Counseling to leave/send messages at the number listed bellow of upcoming appointments.

The reminder of appointments is a courtesy that may or may not occur but you are still obligated to inform America's Family Counseling of any cancelation, 24 hours prior to your appointment for no fee to be assessed:

Check One E-Mail Reminders: ____ Yes ____ No America's Family Counseling may e-mail reminders of upcoming appointments.

Print your email clearly: _____

Check One Text Reminders: ____ Yes ____ No - America's Family Counseling may text reminders of upcoming appointments.

Phone Number: _____

Cell Phone Carrier (for text messages) (ex. Verizon, etc.): _____

Initial here _____

Child Care Release

America's Family Counseling does not provide childcare and is not responsible for children left unsupervised in the waiting room. Minors must be picked up immediately following their appointment on time. If you must leave your child in the waiting room for a session, it is your responsibility to provide appropriate supervision for that child. (All children under the age of 12, sitting in the waiting room during your appointment, must be accompanied by an adult.

(Children under 12 may not be left without supervision in the waiting room. Children over the age of 12, sitting in the waiting room during your appointment, his/her behavior must not disturb others in the waiting room or surrounding offices.)

Initial here _____

Emergencies

Typically, an America's Family Counseling employee is available for appointments Monday through Thursday. If you need to speak to your therapist during the week, leave a message with the receptionist or a voicemail at 979-220-4048. In a crisis, where the client is in imminent danger, call the police (911) or go immediately to your local emergency hospital.

If you need to contact your America's Family Counseling therapist in between sessions, please indicate it clearly in your message. Telephone calls are monitored during the day as time allows and we cannot guarantee immediate return calls, but will return your call within 24 business hours.

Initial here _____

Scheduling and Missed Appointments

Please remember that we do not call you to remind you of appointments. If you would like a *courtesy* email or text message reminder, make sure the information on the previous page is present.

Tardy Policy: If you are running late for your appointment, you may still attend. However, your time block will begin and end as originally scheduled to ensure other clients ahead of you are seen in a timely manner.

If you can not make a scheduled appointment, please call and give us at least **24 hours** notice so that we can make the scheduled time available to someone else. If you need to cancel without 24 hours notice and it is an emergency (e.g., illness, car broke down, etc.) there will be no charge. **If it is not an emergency, or if you do not show for an appointment without canceling, you will be charged. Our standard fee for less than 24 hours notice is \$120.00.** If you have **3 no-shows** or 3 instances of canceling without 24 hours notice America's Family Counseling therapists may no longer be able to work with you except in extenuating circumstances.

Initial here

Financial Policy

Payment is expected prior to service. The fee for each session is **\$120.00**. The initial session may last 50-60 minutes; subsequent sessions are 45-50 minutes. If you decide to schedule a follow up session you will be asked to pay in advance to schedule a follow-up session. (Depending on your insurance, you may pay a different fee.)

The fee for **No Show or Late Cancellation (Required 24 Hour Advance Notice)** is **\$120.00**. This fee is a standard policy in our profession

We do offer a package which you and your therapist may discuss to determine if it fits your treatment plan.

PACKAGE SPECIAL: 3 Sessions - \$324.00 (10% savings)
Package must be purchased at one time or on the same day.

Insurance

We are in negotiations with various insurance companies to become an approved provider, but *at this time our office does not take insurance. Most of our services are covered in part by many health insurance plans. Upon request, we will gladly provide you with the completed form needed to request reimbursement from your provider.*

Sometimes insurance companies will deny services; in such a case you are personally responsible for 100% of the fees. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

It is important to note that if you file claims through your insurance company, you are required to have a clinical diagnosis. You may choose not to go through your insurance company if you have concerns about receiving a diagnosis.

Letters/Report Forms: Any request made to America's Family Counseling Center therapist to write letters or complete reports will be assessed a minimum fee of \$25.00 or more depending on length and extent of what is requested. The AFCC therapist will negotiate a fee based on the length of time it takes to complete the work. *Additional fees are charged for lengthy telephone communications and court attendance. Insurance does not cover this fee.*

Initial here

Your signature bellow indicates that you have read and accept this policy. You may receive a copy of this policy upon request. It also indicates that you (the client/ guardian) give permission to America's Family Counseling Center to provide counseling services (to the client) and that this contract is binding to all future sessions you may have with this entity.

Signature of client/Legal Representative Print Name Date

Additional Client Signature Print Name Date

PRIMARY INSURANCE INFORMATION	
Primary Insurance	Secondary Insurance
Insured Name:	Relationship to Client:
DOB:	DOB:
S.S. #	S.S. #
Member Insurance #	Group Plan #
Employer Name	
Employer Address	Employer Phone #

A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE ARE REQUIRED
 PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION
 OUR OFFICE WILL NOT SUBMIT CLAIMS TO YOUR INSURANCE PROVIDER
 YOU WILL BE GIVEN A RECEIPT TO REQUEST REIMBURSEMENT FOR SERVICES

EMERGENCY CONTACT	
Name	Relationship
Phone (Hm)	(Cell)
May we share information regarding appointments or billing inquiries only, with your spouse or an immediate family member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CONSENT FOR SERVICES	
I, _____, consent to treatment for psychological and counseling services at America's Family Counseling Center.	
Client's Name	
Signature	Date:

Thank you.

CLIENT HISTORY

Client's Name: _____

Please check any of the following symptoms that apply:		
Depressed	Anxious	Irritable
Anger	Rage	Fearful
Fatigued	Low Energy	Frustrated
Feeling Worthless	Withdrawn	Heart Palpitations
Feeling Guilty	Crying Spells	Excessive Sweating
Decreased Appetite	Distracted	Nausea
Increased Appetite	Talkative	Dizziness
Eating Disorder	Restlessness	Light-Headedness
Difficulty Sleeping	Poor Impulse Control	Shortness of Breath
Nightmares	Hearing Voices	Trembling
Visual Hallucinations	Diabetes/Hypoglycemia	Abuse Survivor
Thyroid Problems	High Blood Pressure	Seizures
Relationship Difficulties	Socially Unacceptable	Racing or Confused Thoughts
Difficulties at work	Obsessive Thought or Behaviors	Thoughts of Death or Suicide
Unable to Concentrate	Communication Problems	Other: (Explain)
Substance Abuse	Other Addictive Behavior	

Family History: (Describe current living situation, i.e., who lives with you) and some of the circumstances past and present.

Education/Work History: (If applicable, include highest grade completed, types of grades, vocational training, types of jobs held, current sources of income, and any history of military duty.)

Alcohol and Drug History: (If applicable, include frequency, past and present, drinking problems or drug use, attempts to stop.)

America's Family Counseling Center

1716 Briarcrest Drive, # 305

Bryan, Texas 77802

Email:

info@americasfamilycounselingcenter.com

Phone: # 979-220-4048

HIPPA NOTICE OF PRIVACY PRACTICES

I have read the HIPPA Notification of Privacy Policies form and understand the policies, rights and responsibilities outlined in the document. I have been offered a copy of this document.

Signature of Client or Personal Representative

Date

Printed Name of Client or Personal Representative

Description of Client Representative's Authority: _____
(i.e. self, parent, grandparent, guardian sister, brother, etc.)

.....

_____ AFCC Staff Initials

_____ Yes _____ No Copy of HIPPA Document accepted by client.