***Mary Elijah, M. Ed., LPC, RPT***
***12337 Jones Rd., Ste 241***
***Houston TX 77070***
***832.334.9659 (o)***
***888.521.1237 (f)***

Please provide the following information to the best of your knowledge. Incomplete/incorrect information can lead to problems in processing your claims and you will be held responsible.

Date: ________________________________________

Client Name: ____________________________________________ SSN: ________________________________________

Address: __________________________________________________ City: ______________________ St: _____ Zip: __________

Phone: (C) ___________________ (H) ___________________ Other ___________________ Email: _________________________

DOB: ____/____/____ Age: _____ (Please Circle) Gender: M F Marital Status: S M D W Sep Occupation: ___________________

Please initial if OK to contact/leave reminders or confidential messages or texts at Cell: ______ Home: ______ Email: ______

Chief Complaint: ______________________________________________ Referral by: _______________________________

Person to contact in case of an emergency/relationship: ___________________________________ Phone: ________________

Has/Will client seen/see a psychiatrist or counselor? (Please Circle) Yes No Previous Diagnosis: ________________________

If so, when/reason: ___________________________________________________________________________________________

Please list all children with ages/birthdays living in home:

| *Name* | *Age* | *Date of Birth* |
|---|---|---|
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INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARD. *Primary insurance claims will be filed as a courtesy. Secondary insurance claims must be paid in full and a receipt will be provided for client to file with secondary insurance.*

*Insurance Co.--Please Circle: Aetna BCBS/Anthem Cigna United Healthcare/Optum Carelon Other*

Insured's Name: __________________________________________ Relationship to Client: __Self __Spouse __Child __Other

Insured's DOB: _____/_____/_____ Phone: _____________________________________________________________________

Address: ___________________________________________________ City: _______________ St: _____ Zip: ____________

Insured's Employer: __________________________________________ SSN: __________________________________________

Insurance ID: ________________________________________________ Group: ________________________________________

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PERSON RESPONSIBLE FOR PAYMENT:

Name: _________________________________________________________ Phone: ______________________________________

Statement Address: _____________________________________________________________________________________________

*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 the above information.*

Signature: _________________________________________________________ Date: ___________________________________

# Mary Elijah, M. Ed., LPC, RPT – Informed Consent

***Please initial the following:***

________**CONSENT FOR CARE AND TREATMENT:** You may contact your counselor at the office number provided. However, due to my work schedule, I am often not immediately available by telephone. Please leave a voice message and I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your physician or the nearest emergency room.

1. We (I) agree to participate in the services provided by Counselor in effort to resolve current issues or conflicts within my life or that of my family.
2. We (I) understand that the terms "therapist" "therapy" and "counselor" "counseling" may be used interchangeably with counseling documents
3. We (I) agree to support the therapeutic relationship with the counselor and to follow recommendations provided by the counselor, which might include referrals outside of this office.
4. Standard sessions are 45 – 60 minutes long.
5. We (I) understand that Counselor does not provide medication of any kind.
6. We (I) understand that Counselor's main focus is Mental Health Services and that it does not routinely provide court testimony.

________**REQUEST FOR COURT APPEARANCE:** If Counselor is subpoenaed to testify, the charge is $ 250.00 per hour including preparation time, travel time, testifying and any additional time away from the office. I understand and agree that I will pay a **$1,500.00 RETAINER FEE** 72 hours prior to scheduled court appearance.

________**REQUEST FOR RECORDS:**

- Requests for records must be made in writing with original signature. Request must be hand-delivered or delivered via postal service.
- If a copy of client records is requested, there is a fee of $2.00 per page. Copy fees are due prior to release of records.
- Any letter or therapeutic summary is subject to a $75 per hour fee.
- Phone conferences with legal counsel are subject to a $75 per hour fee.

________**CONFIDENTIALITY:** I, the undersigned, have read and understand the confidentiality policy below.

**Information shared with your counselor is confidential and will not be shared except for the reasons cited below:**

- Suspected child abuse/neglect or abuse of disabled adults. The law requires that abuse be reported to the proper authorities in accordance with chapter 261.001 of the Texas Family Code.
- Client is a danger to himself/herself or others. Information will be disclosed to help protect persons from harm.
- Compliance with a court order.

________**PRIVACY PRACTICE:** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law regulations. Upon request, we will provide you with the most recently revised notice on any office visit. I, the undersigned, have read and understand the Health Insurance Portability and Accountability Act ("HIPAA"). A copy is available upon request.

________**ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:** I, the undersigned, assign the payment of government /medical benefits to Counselor. Also, I authorize Counselor to release any medical information necessary to process claims for the services provided.

________**MULTIPLE PARTIES SHARING COST:** I understand and agree that, in the case of more than one person sharing the cost, I am responsible for making all payments, including copays, punctually to Counselor. It will be my responsibility to collect from the other parties involved. I am also responsible for sharing with the other parties all information regarding treatment and finances.

________**RETURN CHECK POLICY:** There will be a $35 fee for each returned check.

________**CANCELLATION POLICY:** Clients who are unable to keep a scheduled appointment must cancel at least 24 hours in advance to prevent a **$75.00 LATE CANCELLATION FEE**. Monday appointments must be canceled by 5:00 p.m. the Friday prior to the appointment. This Late Cancellation Fee insures maximum appointment availability for you and other clients. I have read and understand the Cancellation Policy. I will take full responsibility of any penalties toward my actions.

________**FINANCIAL POLICY STATEMENT:**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for all services rendered. I certify that all the information I have completed is true and correct to the best of my knowledge. I agree to notify you of any changes in status for the above information. I understand pre-certification by my EAP/insurance managed care company is not a guarantee of payment. Final payment determination is made by insured's EAP/insurance at the time each claim is filed. Claims remaining unpaid by client's insurance for 90 days following the final session become client's responsibility.

**I have read and understand the above information and accept FULL RESPONSIBILTY.**

________________________________________ ________________

**Employee/Client/Responsible Party Signature** **Date**

________________________________________

**Printed Name of Responsible Party**

________________________________________ ________________

**Counselor** **Date**