HEALING minds Behavioral Health
Child, Adolescent, Family Counseling

A TRAUMA-FOCUSED COUNSELING PRACTICE

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

CONFIDENTIAL NEW CLIENT INTAKE (CHILD)

Today's Date _____ Client's D.O.B _____

Client's First Name _____ Last Name _____ MI_____

If client is a student, please list school name _____ or N/A _____

Are you interested in having us contact the school counselor? _____ YES _____ NO _____ N/A

CAREGIVER'S CONTACT INFORMATION

First Name _____ Last Name _____

Home/Mailing Address _____
(Street) (City) (St.) (Zip)

Email address (for appointment reminders/administration only) _____

Best number to reach you _____ Alternate number _____

May we send text messages? _____ YES _____ NO May we leave voice messages? _____YES _____ NO

FINANCIAL INFORATION & POLICY/AGREEMENT

Cost of Counseling Service: The private pay out-of-pocket fee for an initial intake appointment with a Licensed Professional Counselors (LPC) is $130.00. The fee for follow up sessions is $110.00 for a 50-55 minute individual session and $120.00 for a 50-55 minute family session. If these established fees present a financial hardship, you are encouraged to speak to the counselor so that either a referral may be given or an agreed upon fee may be set to accommodate your personal and financial needs.

Billing and Payment of Fees: All fees for counseling are to be paid when the services are rendered, unless we agree otherwise or unless you have insurance coverage that requires other arrangements. If I am an in-network provider for your insurance, I will collect the portion of the fee that the insurance does not cover. Payment schedules for other professional services, if applicable, will be agreed to when they are requested. You will pay your fee directly to the counselor unless other arrangements have been made. Healing Minds Behavioral Health accepts the following forms of payment: Cash, Check, MasterCard, Visa, Discover, or American Express (This includes debit cards and cards provided for flexible spending accounts and health savings accounts).

Insurance Reimbursement: If you have health insurance for which I am a contracted provider, I can file insurance claims to help you receive your benefits. Please note that **you, not your insurance company, are responsible for full payment of my fees.** If your insurance changes, you are responsible for notifying my office of this change in writing. **It is important that you find out exactly what mental health services your insurance policy covers.** Your contract with your health insurance company requires that I provide the health insurance company information relevant to the services that I provide to you. **I am required to provide a clinical diagnosis.** Sometimes, I am required to provide

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. In some cases, the insurance companies may share clinical information with a national medical information databank. I can provide you with a copy of any report I submit, at your request. By signing this Agreement, you agree that I can provide requested information to your insurance carrier. Your signature at the end of this document indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may request a copy of this document.

Fees for Declined Credit Cards: A fee of $25.00 will be assessed for every declined credit card. If possible, the counselor will attempt to contact you to correct the matter prior to applying the charge. This is a courtesy that is not guaranteed. Future appointments will not be secured until payment has been received or you and your counselor have come to an alternative and mutual agreement. This agreement should be documented in writing and maintained in the client's records.

Fee Schedule: The Fee Schedule that addresses all fees is as follows and is included below:

Type of Service	Assigned Fee	Notes
Initial psychological diagnostic intake	$130.00	75-90 minutes for first time visit – 90791
Follow-up visit (individual therapy)	$110.00	50-55 minutes – 90834 / 90837
Follow-up visit (family therapy)	$120.00	50-55 minutes – 90847
Missed appointments without 24 hours notice	Full session fee	Fee is applied when 24 hours notice is not provided and counselor and client have not made other arrangements.
Declined Debit/Credit Cards	$25.00	This is applied to all declined debit/credit cards.
Copies of records	$25.00 flat rate	This is a flat rate and must be paid by debit/credit card at time of request.
Request for Clinical Summary	$50.00 flat rate up to 5 pages. Each additional page will be charged at $5 per page.	Additional pages will require additional fees to cover time and materials used in producing the clinical summary.
Extensive email responses	$10.00 per email.	This rate applies to lengthy emails sent in response to yours or sent on your behalf to other healthcare practitioners or parties of interest.
Extensive phone conversations	$1.00 per minute.	This fee is applied if we are unable to speak less than 10 minutes regarding scheduling or other concerns. We are happy to return brief phone calls or schedule an individual session for you at the established rate.

HEALING minds Behavioral Health
Child, Adolescent, Family Counseling

A TRAUMA-FOCUSED COUNSELING PRACTICE

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

DEBIT/CREDIT CARD AUTHORIZATION

I hereby grant Healing Minds Behavioral Health, PLLC permission to process debit/credit card charges.

The security of your personal information is extremely important. We are committed to protecting the security and privacy of any personal information you provide, including any financial information. Please discuss any questions concerning this authorization, the "**FINANCIAL INFORATION & POLICY/AGREEMENT**" with Healing Minds Behavioral Health prior to signing.

This form is requested for all clients and required to be on file.

Name as it appears on card _____

Type of card Visa _____ MC_____ Amex_____ Discover_____

Account # on card _____

Expiration Date _____ Security code (3 or 4 digits on back) _____

Billing address _____

I agree to pay for each session beginning on _____

Signed _____ Date _____

I agree to the provided fee schedule and will maintain financial responsibility for all services relevant to me and/or my child (ren). I have read the information in this document and agree to abide by its terms while engaged in this professional counseling relationship. I have completed this form accurately and the information I have provided is correct, to the best of my knowledge.

I accept this agreement and consent to counseling at Healing Minds Behavioral Health, PLLC.

_____
Caregiver's Name (Please Print)

_____ _____
Caregiver's Signature Date

6502 Bandera Rd Ste. 202B | San Antonio, TX 78238
T: 210.418.2546 F: 210.429.7242 hmbhsa.com

IF YOU PLAN ON USING INSURANCE BENEFITS TO PAY FOR SERVICES, PLEASE COMPLETE THE PORTION BELOW

I, (Print Name)_____ hereby authorize my insurance company benefits to be paid directly to Healing Minds Behavioral Health, PLLC, realizing I am responsible for payment of deductibles, co-pays and any non-covered services. Additionally, I hereby authorize the release of pertinent medical information to insurance carriers. I have read the information in this document and agree to abide by its terms while engaged in this professional counseling relationship. I have completed this form accurately and the information I have provided is correct, to the best of my knowledge.

_____
Signature of Financially Responsible Party

_____ _____
Print Name of Financially Responsible Party Date