Dear Client,

Thank you for choosing Leon Springs Counseling & Life Coaching for your therapy and life coaching needs.

Please keep in mind that successful therapy is a collaborative effort. As professional therapists and life coaches it is our responsibility to support you in identifying specific challenges you are facing and to guide you toward healthy resolutions. As a client it is your responsibility to attend your scheduled therapy sessions consistently. At Leon Springs Counseling & Life Coaching we take the therapeutic commitment very seriously. As such, we encourage you to work with your therapist to schedule appointment times that best accommodate your schedule.

Please understand that we do not accept appointment cancellations with less than 48 hours’ notice. Should a late cancellation occur, you will be charged the feel of your therapy session in its entirety ($135 – 175). Insurance companies do not reimburse missed appointments or appointments cancelled without adequate notice. If you need to cancel an appointment outside of regular business hours, please leave a confidential message on our voicemail.

Congratulations on taking the first step toward a healthier, more balanced life. We look forward to working with you!

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**INITIAL CLIENT CONTACT FORM**

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(street) (city) (zip)  
Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best phone number to reach you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send text messages? YES / NO Voice messages? YES / NO Email messages? YES / NO

Employer or School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation or grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have been with your current employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest level of education you have achieved?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact your PCP? YES / NO

List any significant health problems you may have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you are taking and the dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing physician (if not your PCP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact your prescribing physician? YES / NO

Have you seen a Licensed Counselor before? YES / NO Did you find counseling beneficial? YES / NO

If yes, approximately when, for how long, and with whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you find counseling beneficial? YES / NO / NOT SURE

Who may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **LEON SPRINGS COUNSELING & LIFE COACHING INFORMED CONSENT**

## CONFIDENTIALITY STATEMENT:

All information shared in your treatment is confidential except in circumstances governed by law. If you would like your therapist to confer with another healthcare professional, you will need to sign a consent form to do so. This permission can be revoked by you at any time.

## FINANCIAL AGREEMENT:

The fee for a standard counseling session is $135.00 - $175. Any paperwork that you need completed or letters you need written will be prorated based on this fee. We accept cash and credit cards, payable at the time of service. We do not accept checks. For your convenience your credit card will be automatically billed after every session.

If you choose to use insurance, we will file your claim for you; however, please understand that you are still responsible for your bill. If a deductible is being met, your fee is the contracted rate we have with your insurance company until that deductible is met. If you have co-insurance or a co-payment, then you must pay the co-insurance/co-payment at the time of your appointment. If for any reason your insurance denies our claims, you are still responsible for your bill.

In order to accommodate your busy schedule, Leon Springs Counseling & Life Coaching offers telephone consults, e-mail correspondence, extended therapy sessions and marathon therapy sessions. Per your request, we will also gladly prepare any special forms you may need. Please note that insurance does not reimburse for these services and standard fees apply. Fees are subject to change every six months. We reserve the right to terminate services for nonpayment of fees. Referrals will be given upon request.

# NO-SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you. 48 hours’ notice is required to cancel this visit. The standard fee of $135 -$175 will be charged if you fail to give 48 hours’ notice to cancel. Please note that insurance companies do not reimburse for cancellations.

## EMERGENCIES:

If an emergency arises after business hours please contact 911 or go to your local emergency room.

## PHONE MESSAGES:

All phone messages left at Leon Springs Counseling & Life Coaching are confidential. When possible, messages will be reviewed by your therapist prior to your next scheduled therapy session. If a situation arises where you would like your therapist to return your call, standard fees may apply. Insurance does not reimburse for phone consultations.

## STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **FINANCIAL POLICY AGREEMENT / CREDIT CARD AUTHORIZATION**

I hereby grant Leon Springs Counseling & Life Coaching, LLC, permission to process debit/credit cards and charges. I understand that Leon Springs Counseling & Life Coaching agrees to only charge for services rendered or late cancellations/no-show fees if an appointment is not cancelled with 48 hours’ advance notice. I further understand that I am responsible for any fees that insurance does not cover.

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as it appears on credit card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing address (If different than above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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INSURANCE INFORMATION

I hereby grant Leon Springs Counseling & Life Coaching the authority to submit insurance claims on my behalf; however, I understand that I am financially responsible for co-pays, denied claims, and any fees that insurance does not cover. I further understand that without insurance benefits the cost of counseling is $135 -$175 per therapeutic hour, and that not all therapists associated with Leon Springs Counseling & Life Coaching accept third party reimbursement.

Name of Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Member’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **ELECTRONIC RECORD’S DISCLOSURE:**

Records for each client at Leon Springs Counseling & Life Coaching are stored in a record-keeping system produced and maintained by Therapy Notes. This system is “cloud-based” meaning the records are stored on servers which are connected to the Internet. They are HIPAA Compliant and are protected by federal law from unauthorized use or disclosure.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **CONSENT FOR TRANSMISSION OF PROTECTED HEALTH**

## **CARE INFORMATION BY NON-SECURE MEANS**

Therapy notes will automatically send you notification of upcoming appointments via email. It may become useful during the course of treatment for additional communication via email, text messaging or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your therapist at Leon Springs Counseling & Life Coaching, there is a chance that a third party may be able to intercept and eavesdrop on those messages. (IE Individuals who have access to your phone or computer). If you would prefer not to correspond by these forms of communication, please notify your therapist.

I consent to allow Leon Springs Counseling & Life Coaching to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

* Information related to the scheduling of appointments
* Information related to billing and payments
* Information related to thoughts and discussions formulated during session
* Any other information deemed appropriate by my therapist

I have been informed of the risks, including but not limited to, my confidentiality in treatment of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **HIPPA NOTICE OF PRIVACY PRACTICES**

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information.

Mental health professionals only release information in accordance with state and federal laws and the ethics of the counseling profession in association with the Texas Behavioral Health Executive Council. This notice describes policies related to the use and disclosure of your healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes:

# TREATMENT

To provide, manage or coordinate care to consultants and to referral sources

# PAYMENT

To verify insurance coverage and to process claims and collect fees

# HEALTHCARE OPERATIONS

The review of treatment procedures, the review of business activities, certification, staff training, compliance and licensing activities

# OTHER POSSIBLE USES AND DISCLOSURES WITHOUT YOUR CONSENT

Mandated reporting (risk to self, child or elderly), emergencies, criminal damage, appointment scheduling, treatment alternatives, court-mandated subpoenas.

I have been informed and understand HIPAA notice of privacy practices.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **GOOD FAITH ESTIMATE**

## EXPLANATION OF THE “GOOD FAITH ESTIMATE”:

## Effective January 1, 2022, the “No Surprises Act” ruling went into effect. This ruling requires practitioners to provide a “Good Faith Estimate” regarding out of network care. The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your health care needs for an item or service, a diagnosis, and a reason for therapy.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers are required to inform individuals who are not enrolled in a plan or coverage or a Federal Health Care Program, or not seeking to file a claim with their plan or coverage, of their right to, upon request or at the time of scheduling health care services, to receive a Good Faith Estimate of expected charges.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. A client may be subject to additional charges if complications or special circumstances occur. If this occurs, a client will be provided a new Good Faith Estimate. Additionally, if this occurs, federal law allows a client to dispute the bill if the client and his/her/their therapist has not previously discussed the change and the client has not been given an updated Good Faith Estimate.

The PHSA does not currently apply to any clients who are using insurance benefits, including “out of network benefits” (IE Submitting superbills to insurance for reimbursement).

## COMMON SERVICE FEES AT LEON SPRINGS COUNSELING & LIFE COACHING:

$150 - $190: Initial therapy intake, approximately 45-60 minutes

$135 - $175: Therapy appointment, approximately 45-60 minutes

$55: Completion of forms, printing or copying of client records

$135 - $175: Phone calls and correspondences with outside sources, including written correspondences and letters, charged at the prorated cost of client’s therapy appointment

Late cancellation / no-show fee: Appointments cancelled with less than 48 hours’ notice are responsible for the therapy appointment fee in its entirety ($135 - $175)

$250: Mental Health Evaluation completed by Anna Wong, LPC

$100: Mental Health Evaluation Report completed by Anna Wong, LPC

## EXPECTED COURSE AND LENGTH OF TREATMENT:

Clients are typically seen on a weekly or bi-weekly basis. The duration of treatment is determined collaboratively by the client and therapist, and typically ranges from 3-12 months or longer. Treatment services may be terminated by the client or therapist at any time.

## STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian if client is a minor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Christine Hefel, NPI 1629067293 Anna Wong, NPI 1194037481

Quincy King, NPI 1902085483 Alesia Jones NPI 1922583913