Child & Family Guidance Center of Texoma
CLIENT AND PAYMENT INFORMATION

CLIENT INFORMATION

1. Client's First Name:_____LastName:_____M:_____

Date of Birth: _____Age_____ Gender M F Ethnicity:_____

2. Client's First Name:_____LastName:_____M:_____

Date of Birth: _____Age_____ Gender M F Ethnicity:_____

3. Client's First Name:_____LastName:_____M:_____

Date of Birth: _____Age_____ Gender M F Ethnicity:_____

4. Client's First Name:_____LastName:_____M:_____

Date of Birth: _____Age_____ Gender M F Ethnicity:_____

5. Client's First Name:_____LastName:_____M:_____

Date of Birth: _____Age_____ Gender M F Ethnicity:_____

RESPONSIBLE PARTY/ CONTACT INFORMATION

Parent/ Guardian/Adult Client:_____ DOB:_____

Address:_____City:_____St_____Zip:_____

Phone number(s):_____

OK to call or leave message? Yes No Referred by:_____

If address of client is different please provide:

Address:_____City:_____St_____Zip:_____

DO BOTH BIOLOGICAL PARENTS HAVE THE RIGHT TO CONSENT TO TREATMENT? YES NO
ACCESS RECORDS? YES NO **CONSULT WITH THERAPIST?** YES NO
If you are divorced or obtain legal guardianship, you must show legal proof (divorce decree and/or custody documents)

ARE YOU COURT ORDERED TO RECEIVE COUNSELING SERVICES? YES NO

IS CPS INVOLED IN ANY WAY WITH YOU OR YOUR FAMILY? YES NO

DOES THE CLIENT HAVE INSURANCE? YES NO WHAT TYPE:_____

SLIDING SCALE FEE

If you do not have insurance a sliding scale fee is available to assist those who are unable to pay the full amount for services. The sliding scale program is based on total household net income and family size. A copy of your most recent current pay stub, income tax return, W-2, and/or 1099 of all adults living in the household as well as any child support, unemployment or disability income is required for proof of income.

To qualify, please complete the following and provide proof of income to the front desk.

Name:_____ Relationship to client:_____Annual Income $_____

Name:_____ Relationship to client:_____Annual Income $_____

Total # of People living in household?_____ Total NET household income:_____

Child & Family Guidance Center of Texoma

Client Name(s):_____
(Print)

PLEASE READ AND INITIAL ALL ELEVEN (11) STATEMENTS BELOW

I. I understand that determination for treatment, if any, will be made by **Child & Family Guidance Center of Texoma.** Also, I understand that any such recommendations will be explained, and that I have the option to accept or reject the recommendations.
Initials: _____

II. I certify that I have the **LEGAL AUTHORITY** to authorize and consent for **(NAME OF CLIENT(S)** _____to receive treatment/evaluation at **Child & Family Guidance Center of Texoma**. If applicable, I consent to present a copy of my divorce decree and/or custody document(s), etc., certifying my legal authority to seek psychological services for the named client.
Initials: _____

III. I agree to pay for the cost of psychological services provided at the time of service.
Initials: _____

IV. I authorize payment of medical benefits to the named provider for professional services rendered, and I authorize release of any related information necessary for my treatment and for the filing of insurance.
Initials: _____

V. I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment 24 hours in advance.
Initials: _____

VI. I acknowledge I have read, understood, consent to, and agree to comply with the CFCG Client Service Agreement and CFCG Confidentiality Statement.
Initials: _____

VII. I hereby consent to the use or disclosure of Protected Health Information of the named client(s) for treatment, payment, and health care operations. Please list any restrictions of the named client's mental/medical record that you do not want to disclose:_____
Initials: _____

VIII. I acknowledge I have access to CFGC's HIPAA Notice of Privacy Practices, Office Policies & General Information Agreement for Psychotherapy Services (copies in waiting room or at www.cfgcenter.org).
Initials: _____

IX. If needed, I authorize the CFGC clinician involved in the treatment of myself and/or my child to contact me to discuss confidential information by calling from a landline/CELL PHONE to:
Home phone: Yes No Cell phone: Yes No Work phone: Yes No
Initials: _____

X. I authorize CFGC staff to leave messages via my answering machine/voicemail for appointments, reminders, general mental health information, billing, and/or referral information.
Initials: _____

XI. Authorization is valid until rescinded by me in writing.
Initials: _____

Parent/Guardian/Client/Signature:_____**Date:**_____

Child & Family Guidance Center of Texoma

COURT SERVICES, RECORDS, & CORRESPONDENCE AGREEMENT

I/We hereby understand and agree to the following requirement and charges that I/We may incur if a clinician or any other CFGC staff is involved in a court case or related matter on behalf of myself, my spouse, my children, or my family. I/We understand that these terms are applicable both while I/We are receiving services, as well as following termination. I/We understand that if I or a family member is a victim of a crime that I/We may be eligible for the following fees to be covered by the Texas Crime Victims' Compensation.

COURT ORDERED SERVICES AND CORRESPONDENCE/RECORDS REQUESTS:

A signed copy of the court order or CPS Service Plan must be received by CFGC BEFORE services can be scheduled. Once the order/service plan has been reviewed by the Clinical Director, services will be scheduled per the court order/service plan if CFGC can offer services which will comply with the order.

Fees for Court/Attorney Related Services: ALL FEES FOR COURT TESTIMONY, CORRESPONDENCE AND/OR RECORDS MUST BE PAID IN ADVANCE. COUNSELING SERVICES MUST BE PAID AT TIME OF SERVICE.

1. Phone Consultations with Attorneys, Mediators, Family Court Counselors, District Attorneys:
$25 per 15 minute increments of call.

2. Reports and/or client summary for court, attorneys:
$100.00 per report.

3. Court deposition or court testimony:
$500.00 non-refundable, minimum charge for first required appearance, regardless of actual time spent in court. This amount covers up to 4 hours. Any additional dates or hours of appearance will require payment of $150.00/PER HOUR. Any out–of- COUNTY charges must be reimbursed as above and will include actual out-of-pocket travel expenses, to include mileage and/or transportation costs, tolls, parking fees, meals, and lodging (Based on current IRS mileage rate). *****By law, if a county is more than 150 miles from where a therapist resides or is served, the therapist is NOT required by subpoena to appear or produce documents.**

Requirements

1. Release: For those cases referred by the court system, clients **MUST** sign release of information forms allowing CFGC clinicians to openly communicate with all parties related to the suit. To ensure safety and professionalism of the counseling process, **NO exceptions will be given.**

2. Subpoena: A subpoena must be issued **before** the clinician or any other agency personnel can make a court appearance, deposition appearance, or deliver any records. We request 48 business hours notice before the court date be given in order for the therapist to properly prepare. **Party issuing Subpoena will be financially responsible for ALL related fees.** If therapist is subpoenaed by both parties each party will be responsible for the $500 fee to appear.

3. Fee for Civil Cases If subpoena is delivered for a civil case the process server MUST bring $10.00 to recipient of subpoena. Does not apply in criminal cases.

4. Information for parent/guardian and copies of client records: *NOT COURT RELATED
Per Texas Administrative Code 165.2 copy fees are: $25.00 for the first 20 pages, plus $0.50 for each additional page.
Per Texas Administrative Code 165.2 CFGC has 15 business days after receiving the request to provide the records.

5. Counseling Fees: FEES MAY BE SPLIT EQUALLY BETWEEN PARTIES AND MUST BE PAID AT TIME OF SERVICE.

Intake session $130.00	Regular Session $100.00- $125.00
All other court ordered services	Fees are set according to service requested

6. Completion of disability paperwork: Client must be seen for at least six (6) sessions before paperwork for disability can be completed. A charge of $10 will be incurred for completing the paperwork and must be paid BEFORE completed paperwork is released.

7. Phone conversations with therapist: Counseling sessions may NOT be conducted by phone. However, if you have an emergency, you can speak BRIEFLY to your therapist by phone; however, you will be charged $25 per 15 minute increment after the first 10 minutes.

NOTE: SLIDING SCALE FEES DO NOT APPLY TO COURT ORDERED SERVICES OF TWO (02) OPPOSING PARTIES FOR THEMSELVES OR FOR A MINOR CHILD. UNLESS OTHERWISE NOTED, FEES WILL BE CHARGED AT THE RATES INDICATED ABOVE. FEES MAY BE SPLIT BETWEEN THE PARTIES AND ARE PAYABLE AT TIME OF SERVICE.

I acknowledge I have read, understood, consent to, and agree to comply with the CFCG Court Services, Records & Correspondence Client Service Agreement,

Parent/Guardian/Client/Signature:_____Date:_____

Child & Family Guidance Center of Texoma
804 E. Pecan Grove Road, Sherman, TX 75090
Ph: 903-893-7768 Fax: 903-893-4979

LIMITED RELEASE OF INFORMATION

Client: _____ DOB: _____

I, (Name of client or guardian)_____,
hereby authorize the Child & Family Guidance Center of Texoma (CFGC) to RELEASE OR RECEIVE medical and mental health treatment information and/or records regarding diagnosis and treatment, for the purpose of coordination of care between providers and others involved in my treatment.

RELEASE TO/RECEIVE FROM: _____
(ex. referring physician, relative, CPS, attorney, etc.)

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

Information to be released: ☐ Attendance/dates of service ☐ Diagnosis ☐ Treatment plans/goals
☐Treatment Summary ☐ Other _____

Is there any medical/mental health information that you do not wish to be released? ☐ NO ☐ YES

- I understand that I have a right to receive a copy of this authorization.
- I understand that any cancellation, modification, or revocation of this authorization must be in writing.
- I understand that I have the right to revoke this authorization at any time unless CFGC has taken action in reliance upon it.
- I understand that it is my responsibility to confirm receipt by CFGC of any cancellation, modification, or revocation.
- I understand that CFGC shall not condition treatment upon the signing this authorization and that I have the right to refuse to sign this form.
- I understand that refusing to sign this form does not stop disclosure of health information that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities (referring physicians, other clinical staff/treatment team members at CFGC, and other medical/mental health professionals referred to me by CFGC) as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).
- I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

I, _____ CONSENT to the release of information _____
(Signature of Client/Legal Guardian) Date

EFFECTIVE TIME PERIOD. This authorization is valid for 1 year from the date signed unless another date is specified below.

Only complete this box if you wish to withdraw permission to release information.

I, _____ wish to withdraw my consent to release information on _____.
(Signature of Client/Legal Guardian) Date