Client Information

Janis B. Rice, MA, LPC

16821 Buccaneer – Suite 119
Houston, Texas 77058
Phone: 281-538-8008

info@JanisRice.com
www.JanisRice.com

TODAY'S DATE: _________________

CLIENT:

NAME: ____ *SEX:* ___ *BIRTH DATE:* __________ *AGE:*_______

If Minor, PARENT(s)/GUARDIAN(s): ____

ADDRESS:

STREET: ____

CITY: ______________________________________ *STATE:* ________ *ZIP:* ________________________

EMAIL:

____ *(OK to email?) YES / NO*

PHONES :

(Home) __________________________________ *(OK to call?) YES / NO (OK to leave msg?) YES / NO*

(Cell) __________________________________ *(OK to call?) YES / NO (OK to leave msg?) YES / NO*
(OK to text?) YES / NO

(Work) __________________________________ *(OK to call?) YES / NO (OK to leave msg?) YES / NO*

CLIENT'S EMPLOYER / SCHOOL:

__________________________________*OCCUPATION:* ______________________*HIGHEST LEVEL EDUCATION* _______

SPOUSE/PARTNER:

NAME: ____ *PHONE:* ____________________

RELATIONSHIP STATUS: ( ) Single ( ) Married (years) _______ *( ) Separated ( ) Divorced ( ) Widow/er ( ) Other*

EMERGENCY CONTACT: _____________________________________ *PHONE:* _____________________

RELATIONSHIP: _____________________________ *REFERRED BY:* ______________________________

FAMILY INFORMATION: *(Spouse, Children, Parents, Relatives, Others)*

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP

MEDICAL INFORMATION:

*Primary Care Physician:*____________________________________ *PHONE:* ______________________

Other Physicians Treating You: ______________________________ *PHONE:* ______________________

*Current Medications:*____

____

Office Policies & Procedures

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PRACTICE: The offices in this therapy suite may be shared or used by several mental health practitioners; however, each clinician maintains an independent private practice.

OFFICE HOURS: My office hours are posted on my website. All appointments must be scheduled in advance. It may be possible to arrange appointments outside the posted hours.

APPOINTMENTS: Appointments are scheduled directly with me and last approximately **45** minutes. If the need arises to reschedule or cancel your appointment, please call me at **(281) 538-8008** as soon as you know. If you arrive late for your appointment, your session time cannot be extended.

CANCELLATION POLICY: When you schedule an appointment, I consider that a commitment for you and me to work together to pursue your therapy goals. I am unable to schedule anyone else during your reserved time. Sometimes emergencies arise, but whenever possible, strive to put your health ahead of life's daily interruptions.

I am usually unable to schedule others who desire help on short notice, so I expect you to give me at least 24 hours advance notice if you must cancel an appointment. Insurance companies and Employee Assistance Programs (EAP) will not pay for missed appointments.

If you cannot let me know at least 24 hours in advance that you must cancel or change your appointment, you may be charged a missed appointment fee of $60 for the time you reserved. Forgetting your appointment, unanticipated work commitments, or schedule changes, are not valid excuses for missing an appointment. Other reasons, such as car trouble, traffic, illness, or other emergencies, will be considered on an individual basis.

ACKNOWLEDGEMENT INITIALS ___________

EMERGENCIES: My main business telephone number is **(281) 538-8008**. I am usually in my office during scheduled appointment times, but if I am in session with a client, I cannot be interrupted and will not be available to take phone calls. However, I do check for voice messages frequently. On other days, including week-ends or if I am out of town, I check for messages at least daily.

If you cannot reach me by phone but need to talk to someone urgently, you may wish to call Crisis Intervention of Houston, Inc. at **(713) HOTLINE OR (713) 468-5463**.

If you are in crisis or have a life-threatening emergency, call **911** or go to your nearest emergency room immediately.

ACKNOWLEDGEMENT INITIALS _____________

FEES AND PAYMENT POLICY: If you request that I accept your insurance or Employee Assistance Program (EAP) benefits and if I am contracted with those companies, I will accept that arrangement and file claims for you, in which case you hereby authorize payment directly to me. Your plan may require diagnostic and treatment information to be released to them before they will authorize payment. If you request that I accept your insurance or EAP benefits, I am obligated to comply with their requests for information and you hereby authorize release of that information. Alternatively, I will not disclose any information to them if you decide to pay for my services out-of-pocket.

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If your insurance company happens to be one with which I am not contracted, known as "out-of-network", self-pay rates will apply and I will provide receipts so you can submit claims to them. Please understand that you may or may not receive reimbursement.

Insurance deductibles, co-payments, and co-insurance are your responsibility, as are any balances on your account. **If your insurance company denies payment for any reason** -- **you are ultimately responsible for payment for my services**.

If I am not contracted with your EAP, I will not be able to provide services to you, and you will have to ask them for referral to another provider in their network.

If you do not have insurance or EAP coverage, or decide not to use your benefits, self-pay sessions are available as follows:

Initial evaluation and assessment session	**$125**
Follow-up session (45 minutes)	**$100**
Follow-up session (60 minutes)	**$120**

All payments are due when services are rendered. Payments may be made by cash, personal check, Visa, or MasterCard. There is a charge of **$25** for returned checks and **$5** for declined credit cards.

I reserve the right to pursue collection of unpaid amounts using the services of a collection agency, small claims court, or an attorney.

ACKNOWLEDGEMENT INITIALS __________

CONFIDENTIALITY: You have a legal and professional right to confidentiality of what we discuss in our sessions, and even to the fact that you are in therapy with me. I am required by federal law to safeguard that confidentiality. Except in certain situations, such as those mandated by law, information will not be released to anyone without your prior written authorization. The major exceptions to confidentiality are issues involving child or elder abuse or neglect, threatened harm to self or others, mandated court orders, requests by parent(s) of minor client(s), and third party insurance information requirements. This information is explained in further detail in my **Notice of Privacy Practices (NPP)** which you hereby acknowledge that you have been provided.

ACKNOWLEDGEMENT INITIALS __________

I confirm that Janis B. Rice, MA, LPC has discussed the above information with me. My signature below indicates my understanding of, and my agreement to accept, these policies and procedures.

____ __________ __________________

Client or Client Representative Signature Initials Date

Consent to Use and Disclose Your Health Information

Janis B. Rice, MA, LPC
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info@JanisRice.com
www.JanisRice.com

This is an agreement between you, ____,
and me, Janis B. Rice, MA, LPC, authorizing how I may use and disclose your health information. The word "you" below can also mean your spouse, your child(ren), a relative, or any other person(s) you designate if you have written his or her name(s) here: ____________________________________

____

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls **Protected Health Information (PHI)** about you. I need to use this information to decide on what treatment is best for you and to provide any **Treatment** to you. I may also share this information with others who need it to arrange **Payment** for your treatment, or for internal business **Operations** – collectively referred to in the law as **TPO**.

By signing this form, you are agreeing to let me use and disclose your information for **TPO** purposes. My **Notice of Privacy Practices (NPP)** explains in detail your health information privacy rights and how I may or may not use and share your information. Please read the **NPP** before you sign this Consent form.

If you do not sign this Consent form and agree to my Notice of Privacy Practices, I cannot treat you.

In the future, I may change how I use and share your information and may change my **Notice of Privacy Practices (NPP)**, which you hereby acknowledge you have been provided. If I do change it, you can get a current copy from my office, by contacting me by phone at (281) 538-8008, or by mailing a request to: 2951 Marina Bay Drive #130-114, League City, TX 77573.

If you are concerned about the use or disclosing of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or operations purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to those limitations. However, if I do agree, I promise to do as you asked.

After you have signed this **Consent**, you have the right to revoke it (by writing a letter to me at the above mailing address telling me you no longer consent) and I will comply with your wishes from that time on, but if I have already used or shared some of your information I cannot change that.

____ ________________________
Signature of client or his or her personal representative — Date

____ ________________________
Printed name of client or personal representative — Relationship to client

____
Description of personal representative's authority