MOTIVATIONS COUNSELING PLLC
14090 Southwest Freeway, Suite 300
Sugar Land, TX 77478
(281) 858-3001

Client Information

Today's Date: ______________________

Client Name: ____

How did you find Motivations Counseling? ____

Motivations Counseling has my permission to contact referring source to thank them.

☐ Y ☐ N Telephone: ________________ Initial: _____

Date of Birth ____________ Age ____ Gender ☐ M ☐ F

Street Address ____

City/Zip ____

Phone Numbers: **May Leave Message?**

Home _______________________ ☐ Y ☐ N

Work _______________________ ☐ Y ☐ N

Mobile _______________________ ☐ Y ☐ N

Text: ☐ Y ☐ N

Email ____ ☐ Y ☐ N

Would you like to be reminded about appointments via Text Message? ☐ Y ☐ N

Employer Name: ______________________________ Occupation: ________________________

Spouse/Partner's Name:________________________________ Date of Birth: ____________

Street Address ____

City/Zip ____ Telephone #: _______________

Client Information (page 2)

Email ____

Employer Name: ______________________________ Occupation: ________________________

Person to Contact in Case of Emergency: ____

Relationship to Client: _________________ Phone Number (s) __________________________

Please list your current medications and dosages, if known: ___________________________
____
____

If you have received previous therapy please provide information.

Name of Therapist: ____

Therapist's Phone Number: ____

Name of Primary Physician: ____

Physician's Phone Number: ____________________________

I authorize **Motivations Counseling** to contact health care providers and for consultations and discussions regarding my treatment. ☐ Y ☐ N Initial: _____

What is your reason for seeking counseling now?
____
____
____

Who else lives at your address? Please list below:

Name	Occupation or School Grade Level	Relationship	Date of Birth	Previously in therapy? When? Where or with whom?

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MOTIVATIONS COUNSELING PLLC
POLICIES AND INFORMED CONSENT FOR SERVICES

CLIENT NAME: ________________________ **PARENT/GUARDIAN NAME:** __________________________
(If client is under 18 yrs. old)

WELCOME TO MOTIVATIONS COUNSELING PLLC ("Motivations Counseling"). We recognize that your decision to seek counseling is an important investment in your life. We are privileged that you have chosen the staff at Motivations Counseling to work with you at this time. We are committed to enhancing growth, healing, and wholeness for individuals, couples, families, and our community.

Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. Your therapist will be pleased to discuss any questions or concerns you may have. We ask that you read the following important information regarding Motivations Counseling policies. Your signature will be requested at the end of this document to give your informed consent for services.

COUNSELING: Your first visit(s) will be a detailed assessment in which you and your therapist will explore your concerns. If you both agree that the therapist can address your therapeutic needs, a plan of treatment will be developed. If a determination is made that other services or providers would be more appropriate to meet your needs, your therapist will provide you with referral information.

INTEGRATION OF MIND, BODY, SPIRIT: Services provided in our counseling agency represent a broad array of theoretical orientations that may include client centered approaches, family systems therapy, cognitive behavioral therapy, faith informed treatment, and solution focused therapy. This philosophy of integration allows for the belief system of our clients to be central in treatment. Our clinicians are trained to integrate the client's own faith traditions in whatever manner is meaningful to the client. For those who do not find that matters of faith are important in their treatment, our clinicians will respect that. Our therapists do not promote a faith tradition nor do they require that to be central to treatment. Spiritual assessment is offered to anyone who would value a faith based/Christian informed approach.

CONFIDENTIALITY: Discussions between a therapist and a client are confidential. Our staff therapists follow all ethical standards prescribed by state and federal law. Our therapists are required by practice guidelines and standards of care to keep records of your counseling. However, no information will be released without your written consent unless mandated by law or as otherwise stipulated in the Motivations Counseling Notice of Privacy Practices provided to you.

APPOINTMENTS: Services are provided by appointment only. Appointments are typically scheduled on a weekly basis and are 45-50 minutes in length. More frequent, or less frequent sessions may also be scheduled according to your individualized treatment plan. Please be on time or 5 minutes early for each appointment. Our therapists strive to begin and end each session on time. If you are late, you will lose valuable time from your appointment. If you must cancel or reschedule your appointment, please call the office at least 24 hours in advance so that the time set aside for your session may be utilized. There is no charge for timely cancelled appointments. However, you will be held financially responsible for the time reserved for you if you fail to cancel with less than 24 hours advance notice. **Cancellations made less than 24 hours prior to the appointment and missed appointments without notification will be billed to you at a "missed appointment" contracted rate.** Late cancellations and missed appointments are not covered by insurance. Should we need to charge you for a missed appointment and you are using insurance benefits, please note that you will be responsible for the full contracted fee, not just your usual copay. **Please initial your understanding of this appointment policy:________.**

PAYMENT/INSURANCE FILING: Payment of fees, including any required copays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using out-of-network insurance benefits, Motivations Counseling will provide an itemized superbill for you to submit to your insurance company for reimbursement.

A $40.00 returned check fee will be billed to you for any checks returned from the bank for any reason (e.g. insufficient funds, stop payment, etc.).

FEES FOR THERAPY DOCUMENTATION: If you require a written copy of your treatment plan, therapist notes, or other documentation related to your therapy, the fee for these written requests is as follows:

- Each request: $35

FEES FOR REQUESTS FOR WRITTEN LETTERS: If you require a letter to be written and sent to a third party regarding any part of your treatment, we will need you to sign an Authorization for Release of Information form. The fee for these written requests are as follows:

- Single page letter to a third party: $125
- Additional pages will be billed at a rate of $125/hour

COURT AND LEGAL FEES: We will need you to sign an Authorization for Release of Information form should you become involved in any legal proceedings that require your therapist's participation. If this does occur, you will be expected to pay for the professional time even if called to testify by another party. Going to court is expensive in both time and money, therefore clients are sternly discouraged from having their therapist subpoenaed. Remember, your therapist's testimony will be to the facts of the case and his/her professional opinion and may or may not be in your favor. However, should you choose to have your attorney subpoena your therapist, on the day your therapist receives the subpoena, your account will be charged a non-refundable $1500 retainer fee. This fee is non-refundable even if the case does not go to court.

If the case does go to court, the following fees apply and must be paid in full by the end of the court day.

1. Preparation time (including submission of records): $225/hour (no less than one hour)
2. Phone calls or emails with your attorney, the attorney's office personnel, or the court: $225/hour (billed in 15-minute increments)
3. Depositions: $225/hour (no less than one hour)
4. Time required to give testimony (this includes wait time prior to the hearing and will be charged whether testimony is given or not): $225/hour
5. Mileage: 58.0¢ per mile (travel to and from will be charged in accordance with the IRS Standard Mileage Rate)
6. Any expenses such as parking, meals, or snacks/drinks
7. All attorney fees and costs incurred by the therapist as a result of the legal action
8. Time away from the office due to depositions/testimony: $225/hour (no less than one hour)
9. Time away from other employment that the therapist must take time off for: $225/hour
10. Filing a document with the court: $100

If a subpoena or notice to meet with an attorney(s) is received without a 72-hour notice, there will be an additional $500 "express" charge. If the case is reset with less than 3 business days' notice, you will be charged an additional $500 which is non-refundable. Finally, all fees are doubled if the counselor had scheduled plans to go out of town.

URGENT NEEDS: You may encounter a need which requires prompt attention. If this occurs during regular business hours, please leave a message for your therapist regarding the nature and urgency of the circumstances. Your therapist will make every attempt to call back promptly, schedule you as soon as possible, or offer other options. If you would like to schedule an appointment, you may also contact the front desk. If an urgent need arises after hours or on a weekend, call the main Motivations Counseling number and follow the directions to leave a message for the on-call therapist. Your call will be returned as soon as the message is received by the on-call therapist. However, **if you are experiencing a life-threatening emergency, call 911 or go to the nearest emergency room for immediate assistance. Please initial your understanding of this emergency policy: _________.**

BENEFITS AND RISKS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any temporary discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. Motivations Counseling and your therapist cannot guarantee these benefits. It is our desire, however, to work with you to attain your personal goals and to meet the needs for which you have sought help.

MEDICARE BENEFITS POLICY: Our therapists and clinical social workers either do not bill, or have opted-out of billing Medicare for psychotherapy services for a two-year period.

Please check whichever applies to you. Are you currently a Medicare beneficiary?
Yes ___ No ___

If you are a Medicare beneficiary, under the terms of this private contract, you:

- agree that you are not facing an emergency or urgent health situation
- agree to forego Medicare coverage and payment for services by the clinical social worker during the two year opt-out period
- agree that you will not bill Medicare nor ask the clinical social worker to bill Medicare
- agree to be liable for charges of the clinical social worker without any limits that would otherwise be imposed by Medicare
- acknowledge that Medigap will not make payment for services and other supplementary insurers may not pay either
- acknowledge that you have the right to receive services from a clinical social worker or other practitioner for whom Medicare coverage and payment would be available
- acknowledge that you have received a copy of this private agreement from the social worker

Please initial your understanding of this Medicare policy: ________.

Therapist section (if applicable):

_______________________________________ _______________________________________
Medicare - Effective Opt-Out Date Medicare - Opt-out Expiration Date

TERMINATION/ENDING THERAPY: Therapy is concluded when the goals stipulated in your treatment plan have been met, or at any point at which you choose to terminate services. It is recommended that termination be discussed with your therapist in at least one face-to-face concluding appointment rather than by telephone, mail, or by simply failing to make a next appointment. Your therapist will discuss with you plans for your aftercare or any needed referrals that will promote your continued growth.

CONSENT TO TREATMENT: By signing this Informed Consent for Services as the Client or Guardian of said Client, **I acknowledge that I have read, understand, and agree to the terms and conditions contained in this document**. I have been given the opportunity to address any questions or request clarification for anything that is unclear to me.

I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_______________________________________ _______________________________________
Signature of Client Date

In consenting to services for a child under 18 years of age, I attest that I have legal responsibility and I am authorized to seek treatment for this child and that no additional person is also required to authorize treatment.

I acknowledge I must provide proper documentation, such as a copy of Legal Guardianship, Custody Agreement, and / or Power of Attorney to verify I have legal authority to seek care for my child. These forms must be provided to your therapist within the first 2 office visits. Initial here: _________

____ _______________________________________

Signature of Parent, Guardian or Personal Representative* Date

*If Personal Representative, describe authority to act for this person: ____

____ _______________________________________

Therapist Date

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Telehealth Informed Consent

To better serve the needs of the community, healthcare services are now available by interactive video communications and/or by the electronic transmission of information. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals ("Treatment Providers") at different locations to share individual client clinical information for the purpose of improving client care. Treatment Providers may include, but are not limited to, counselors and marriage and family therapists. The information may be used for healthcare delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education, and may include client clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and information. It is important that you understand and agree to the following statements.

Expected Benefits:

1. Improved access to healthcare by enabling a client to remain at a remote site while consulting with Treatment Provider.
2. More efficient healthcare evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

Although rare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;
3. The transmission of client's clinical information could be interrupted by unauthorized persons; and/or the electronic storage of my clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgment errors.

Necessity of In-Person Evaluation:

A variety of alternative methods of clinical care may be available. A client may request alternative methods of care to telehealth from Treatment Provider. Telehealth-based services and care may not be as complete as face-to-face services. There are potential risks and benefits associated with any form of treatment, and that despite client efforts and the efforts of Treatment Provider, a condition may not improve, and in some cases may even get worse. If it becomes clear that the telehealth modality is unable to provide adequate treatment, the Treatment Provider will make recommendations to the client for further care.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of clinical information also apply to telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to:

   a. information demonstrating a probability of imminent physical injury to myself or others;
   b. suspicion of abuse of a child, elder, or individual with a disability; and
   c. if my clinical records are subpoenaed by a judge.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
4. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.
5. I agree to provide verification of Texas residency and inform my Treatment Provider immediately of any changes to residency.
6. **For minors seeking treatment**: I agree to verify guardianship of minors seeking treatment by providing requested documentation.
7. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.

In case of life-threatening emergency, call 911 immediately.

Please notify your therapist for any concerns you may have regarding your care. An individual who wishes to file a complaint against a licensed therapist may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information. *This number is for complaints only.* Please direct routine calls and correspondence to the phone number and address on the "Contact Us" page.

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of telehealth in my (or my child’s if said child is the client) clinical care.

I hereby authorize Motivations Counseling PLLC and its employees, agents and independent contractors, to use telehealth in the course of my (or my child’s) diagnosis and treatment.

______________________________ ______________________________

(Signature) (Date)

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MOTIVATIONS COUNSELING PLLC
FEE AGREEMENT

Date: ______________

Client: _______________________________________

Self-Pay:

- **Individual Session (1st and subsequent appointments):** $ **150.00**
  - Additional 30 minutes: $75.00

- **Individual Session with EMDR (1st and subsequent appointments):** $ **150.00**
  - Additional 30 minutes: $75.00

- **Couples Session Fee (1st and subsequent appointments):** $ **150.00**
  - Additional 30 minutes: $75.00

Missed appointments and late cancellations (less than 24 hours) are billed to clients at normal session rate:
$ 150 (Individual Session, Couples or EMDR Session)

PAYOR SIGNATURE ____

Form updated: 4/30/2019 File #: ____________________

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www.MotivationsCounseling.com

Credit Card on File

This form is to be used for manual entry of credit card information for payment of therapy services, and/or late cancellations. The client / parent will always be notified in advance when this form of payment will be used.

Please complete:

- Name on Credit Card: ______________________________________
- Credit Card #: ______________________________________
- Expiration Date: ______________________________________
- CVV2 Code: ______________________________________
- Billing Zip Code: ______________________________________

_____________________________ _________________________

Signature (for Authorization) Date

Client Name*: ________________________ File #: ________________________

*All child / teen files must have Credit Card on File.

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MOTIVATIONS COUNSELING PLLC

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name___________________________________**Date of Birth**____________________

Parent/Guardian Name____
(if client under 18 years old)

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Motivations Counseling PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Motivations Counseling PLLC Privacy Officer, Susan Baker, M.Ed., LPC or contact the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.

____ _______________________
Signature of Client **Date**

____ _______________________
Signature of Parent, Guardian or Personal Representative* **Date**
(if client is under 18 years of age)

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

____

☐ Client Refuses to Acknowledge Receipt:

____ _______________________
Signature of Staff Member **Date**