Cynthia R. Carter, M.S., LPC, LMFT
14525 FM 529, Suite 200, Houston, TX 77095
(281) 746-3406 phone
(281) 274-9353 fax

NEW CLIENT FORMS - Minors

(Please Print)

Parent Name:____

Minor Client Name: ____

Sex: ________ Age: ______ Birthdate: M____ D ____ Y______ Grade: _______

Address:_____________________________________ City: ___________ St:____ Zip:________

Cell Phone:______________ _______________ Secondary:__________ ________________________

Email:____

Preferred Contact Method: Cell_____ Secondary______ Email______

Can I leave a voicemail at the phone numbers provided? Yes ______ No ______

I give permission to ________________________________ to request my child's appointment time and date.

List any Chronic Health condition: ____

Current
Medications/Dosage:____

Current Behavioral Health Diagnosis (if applicable):____

Please list other family members who live in the home. You may use back of page if needed:

Name:______________________ Age:_____ Name:______________________ Age:_____
Name:______________________ Age:_____ Name:______________________ Age:_____

Biological Parents status: Married ___ Divorced ___ Separated ___ Parent deceased ___ Never Married ____

Biological Co-Parent Name: ____

Please describe *custody arrangements between Biological parents: __________________________________
____

* I understand that Cynthia R. Carter, M.S., LPC, LMFT has requested a copy of my divorce decree and the most recent amendments to this decree and custody arrangements. _______ (parent initials).

Reasons for coming to counseling:

Referral source (How did you hear about us?): ____

Service Type	Service Description	Service Fee
STANDARD BILLABLE RATE	One Session (40-45 minutes)	$140.00
GROUP/WORKSHOP RATE	Time Varies By Group; Generally 50-55 Minutes	Varies By Group
PHONE/EMAIL RATE	Over 10 minutes billed at	$1.50/minute
APPOINTMENT NO SHOW FEE	Cancellation less than 24 hours or No Show	$60.00
LETTERS FOR COURT/WORK/SCHOOL	72 hrs notice must be given; Does Not Include School/Work Excuse	$35.00/letter
REQUEST/COPY OF RECORDS	$50.00 for first 25 pages	$1.00/page thereafter

Please read and review the following information carefully:

Cynthia R. Carter, M.S., LPC, LMFT provides therapy for individuals, couples, and families. I occasionally offer adult, children and teen groups and workshops. For questions about groups or workshops please talk with our office staff or with myself. Cynthia R. Carter does not provide medication of any kind.

What to Expect from Therapy: I work from a systemic perspective, which means I view clients in the context of their immediate family and larger social system as being important resources in solving life's problems. Goals for therapy are always established through collaboration with the client(s). I work from a structural/solution-focused orientation, which means that I assist couples and families in organizing their relationships so that resources can be brought to bear on the problems being presented. Techniques that are often employed are psycho-education, modeling and role playing more positive and effective communication skills, along with between session assignments and goals created by the client(s) and their therapist. The completion of homework and client efforts to reach their goals set between sessions is necessary to get the most from the therapeutic experience.

What I Expect From Clients: Clients must make their own decisions regarding such things as educational changes, changes in marital status such as separation, divorce, reconciliation, parenting and co-parenting, custody and visitation. **I am here to help you think through the possibilities and consequences of decisions, but I am not going to make a specific decision for you.**

Privileged Communication: I am required to abide by the professional practice standards for a licensee in the State of Texas. I do not disclose client confidences and information to any third party, except for materials shared during supervision, without a client's written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the proper authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled adult abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm.

Certain types of litigation (such as child custody suits) may lead to court-ordered release of information without your consent. If a complaint is made against the therapist license, that therapist may use case information to defend this complaint. When working with couples, families, and/or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, I will not release any information about either or both spouses that have been seen for marital therapy to an attorney without signed authorizations from both spouses. Cynthia R. Carter, M.S., LPC, LMFT and/or Banyan Counseling Network and its staff make every effort to comply with HIPAA privacy laws and the policy information is available on the front desk. A copy will be supplied upon request.

After-Hours Emergencies: When the office staff is unavailable to answer calls or after normal office hours, you may leave a message on Cynthia R. Carter and/or Banyan Counseling Network main office voicemail and your call will be returned as soon as possible. In an emergency situation or when an immediate response is necessary, please call 911 or go to your nearest emergency room.

Records and Court: Client files and records are the property of Cynthia R. Carter. Client files and records will be maintained in accordance with current State and Federal laws and will consider the end date of a treatment episode as the basis for file destruction. Cynthia R. Carter **does not provide Custody Evaluations or Expert Witness court testimony.** If I am asked to produce a copy of client records, there is a minimum charge of **$50.00 for up to 25 pages** and a cost of **$1.00 per page thereafter**. Copy fees are due prior to release of the record. If Cynthia R. Carter is subpoenaed by a judge to testify, the minimum charge is **$750.00**, due prior to the court date, for any time up to **three hours** (this includes preparation time, travel, and testifying), additional time is charged at **$250.00 per hour**.

Potential Risks and Benefits of Therapy:

* Making changes through the therapy process may produce other unforeseen changes in a person's life.

* A risk in the therapy process could be feeling worse before feeling better.

* Changes in relationship patterns that may result from therapy may produce unpredicted and/or possibly adverse responses from other people in the client's social system.

* A result of therapy may be a realization on the part of the client that there are issues that may not have surfaced prior to the onset of the therapeutic relationship.

*Couple or family conflicts may initially intensify as feelings are expressed. Individuals in couple or family therapy may find that partners or family members are not willing to change.

Please read following statements carefully and initial where indicated:

Appointment Reservations: The therapy room is reserved specifically for you. Appointments are usually scheduled one time per week for approximately 40-45 minutes, with the initial session devoted to gathering all necessary information. The entire therapy process may take an average of eight to ten sessions.

________ I understand that, if applicable, I will be charged a fee of **$60.00** for the following reasons*:

- **If I do not show up for my appointment and have not given proper cancellation notice**
- **If I do not cancel my appointment 24 hours before my scheduled session time**
- **If I am more than 15 minutes late and the therapist has already left the office**

________ I understand that it is acceptable to leave a voicemail at 281-746-3406 or to send an email to yourtherapist@CynthiaRCarterTherapy.com for a cancellation notice in order to avoid a no show fee. If I am running late I can make a courtesy call to Cynthia R. Carter.

________ I understand that if I reschedule, cancel, or no show my appointment 3 times in a row that I must pre-pay at the current private pay rate prior to making any future appointments. No refunds will be given if pre-pay appointments are cancelled or missed.

_________ I understand that all fees due are to be paid at the time services are rendered. Payment may be by cash, check, select credit cards and flexible spending/health savings account credit cards. Advanced payments are to be used within 2 weeks of payment date. No refunds on services or advanced payments, including clients on a prepay plan.

_________ I understand that a **$30.00** fee will be charged at or before the next session for returned checks or declined/invalid credit cards in addition to session fees due. If fee is unable to be charged, an invoice will be mailed to the address listed on page 1 of this form.

_________ I understand that I am responsible for any additional fees incurred by Cynthia R. Carter for any disputed credit card charges. Prior to disputing credit card charges from me, please discuss the charges with me in order to avoid these fees.

_________ I understand that my client file will be closed after a 30 day lapse in services. When I return I understand my fee will be at the current, standard rate or private pay discount rate.

_________ I understand I am required to provide Cynthia R.Carter, M.S., LPC, LMFT with my credit card number and authorize them to charge my credit card account for all late cancellation or no show balances due to cover any missed appointments and balances due. I understand that this form is valid unless I cancel the authorization through written notice to Cynthia R. Carter, M.S., LPC, LMFT*.

Name of Person Financially Responsible to Cynthia R. Carter, M.S., LPC, LMFT:

____

TYPE OF CARD: ____ visa ____ mc ____ discover ____ other _______________

Name on Credit Card: ____

Billing Address: ____

Credit Card Number: ____

Expiration Date: ______(M)_______(Y) CIC #: ______________ (3 digits on back)

Cardholder/Person Financially Responsible Signature: ____

Date _____________________________

<u>Please read following statements carefully and initial ONE as applicable</u>:

Financial Responsibility:

Behavioral Health Insurance (*subject to Late Cancellation/No Show fee):

_______ I am requesting that Cynthia R. Carter, M.S., LPC, LMFT verify my Behavioral Health Insurance benefits and, as a courtesy Cynthia R. Carter will file payments made by me accordingly and any reimbursements from insurance will be sent to the responsible party on file with my insurance plan. I understand the standard, current rate applies and that I am responsible for paying the contracted rates **(shown below)** in full prior to the start of my session, unless other arrangements are made in advance with my therapist. I understand I am responsible for charges not covered by my insurance. I give my permission to Cynthia R. Carter and third party billing company to disclose certain information to my insurance company, such as diagnosis, treatment plan (dates of service, services performed, etc.) and any other information requested by my insurance company as needed in order to process my claim accordingly.

Insurance Plan	Initial Client Appointment ages 13 up	Initial Client Appointment ages 12 & under	Individual Appointment ages 13 & up	Individual Appointment 12 & under	Client & Family Appointment During All or Part of the Session

Out of Network Behavioral Health Insurance (*subject to Late Cancellation/No Show fee):

_______ I am requesting that Cynthia R. Carter, M.S., LPC, LMFT verify my Out of Network Behavioral Health Insurance benefits and file accordingly. I understand the standard, current rate applies. I understand I am responsible for charges not covered by my insurance and for balances due should my insurance not reimburse Cynthia R. Carter accordingly. I understand I am financially responsible to Cynthia R. Carter for any fees not covered or paid by my insurance carrier. I give my permission to Cynthia R. Carter and third party billing company to disclose certain information to my insurance company, such as diagnosis, treatment plan (dates of service, services performed, etc.) and any other information requested by my insurance company as needed in order to process my claim accordingly. My Out of Network copay is **<u>$60.00</u>** and is due prior to each session.

EAP:

________ I am requesting that Cynthia R. Carter, M.S., LPC, LMFT verify my EAP benefits and file accordingly. I understand the standard, current rate applies. I give my permission to Cynthia R. Carter and/or third party billing company to disclose certain information to my insurance company, such as diagnosis, treatment plan (dates of service, services performed, etc.) and any other information requested by my EAP/Insurance Company as needed in order to process my claim accordingly.

Medicaid & CHIP:

________ I am requesting that Cynthia R. Carter, M.S., LPC, LMFT verify my Behavioral Health Medicaid and/or CHIP benefits and file accordingly. I understand the standard, current rate applies. I give my permission to Cynthia R. Carter and third party billing company to disclose certain information to my insurance company, such as diagnosis, treatment plan (dates of service, services performed, etc.) and any other information requested by my Insurance Company as needed in order to process my claim accordingly.

Private Pay (*subject to Late Cancellation/No Show fee):

________ I understand that Cynthia R. Carter, M.S., LPC, LMFT 's current, standard rate is $140.00/session and that I am opting to pay for services with cash, credit, check, or flexible spending/health savings account at the current private pay discount rate of **<u>$95.00</u>** prior to each session. I understand I will not require Cynthia R. Carter to verify my insurance benefits or file accordingly. If at any time I choose to have Cynthia R. Carter verify and/or file with my insurance, the current, standard rate applies from that point forward.

I acknowledge that I have read this document in its entirety and understand the above policy above information regarding the services provided client rights, and limits of confidentiality.   I have read, understand and accept the Financial Responsibility & Appointment Cancellation Policy Statement. I also acknowledge my review of HIPAA & Additional Privacy Information available in the office.

I, ____, give consent for treatment of minor client for Cynthia R. Carter
(Parent/Guardian of Minor Client)

to conduct therapy with my ______________________________, ________________________________.
(Relationship to Minor) (Name of Minor Client)

____ ______________________
Signature of Parent or Legal Guardian Date

____ ______________________
Signature of Cynthia R. Carter, M.S., LPC, LMFT Date