

Mont Belvieu Counseling

Leah E. Neese, M.A., LPC

P.O. Box 297

Mont Belvieu, TX 77580

(713) 825-0086

www.montbelvieu counseling.com

Child History

Client/Child's Name:	Date of Birth:	Today's Date:
Address:		

Emergency Contact Name:	Relationship:
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Home Phone Number	Work Phone Number	Cell Number		
Where may I contact you?	Home	Work	Cell	Email
		(Circle all that apply)		

School Name	School Address
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Who Referred You to Ms. Neese?			
Does your child have a primary care physician and/or psychiatrist?		If so, may I contact them if needed?	
Yes	No	Yes	No

If you grant me permission to contact your PCP or psychiatrist, please provide their name & telephone number:

Please list any medication(s) your child is presently taking (prescription & over the counter):

Mother's Name:	Address	Phone Number
Father's Name:	Address	Phone Number

Billing Information

Responsible Party:		
How will you be paying for services today and in the future? (circle all that apply) Cash/Check PayPal Insurance		
Address:		
Phone Number:	Home	Work
		Cell
SSN:	Date of Birth	
Relationship to Client		
<i>**In the event that there is a missed appointment, no-show, or cancellation without twenty-four hours notice, I authorize Leah E. Neese, M.A., LPC to use the following credit card information for payment. (**REQUIRED INFORMATION**)</i>		
Discover Visa MasterCard American Express (Circle one)		
Name as it Appears on Card:	Card Number:	Expiration Date:
Three-digit number printed on the back of your card (AMEX has a 4-digit number printed on the front of the card):		
Email:	Home Phone Number:	
Signature:	Date:	

Insurance Information - Primary Carrier Only

Insurance Company:	Policy ID:	Group Number:
Name of Insured:	Insured's Date of Birth:	Insured's Employer:
Insured's Phone Number:		Insurance Company's Phone Number (back of card):

Release of Information

Your privacy is important to me and I want to protect your personal health information. If there is someone who you would like for me to release information to, please ask for the Release of Information paperwork.

The following confidential information will be used to provide me with a more complete understanding of your child. If you have any doubts about your answer, respond to the best of your ability. Thank you for your assistance.

Referral Situation

What recent events or emotional/behavioral problems have led to you seeking assistance for your child?

Please state in your own words the nature of your child's present problems/symptoms:

Were your child's problems/symptoms first noted by someone else? If so, by whom?

Please describe briefly your goals and expectations for your child and what you hope may be accomplished by this evaluation or through counseling:

In a few words, what do you think counseling is all about?

How long do you think your counseling should last?

Child's Personal and Social History

Date of Birth:	Place of Birth:
Number of Brothers:	Siblings: Brothers' Ages:
Number of Sisters:	Sisters' Ages:
Father: Living? If alive, give father's present age: If deceased, give his age at time of death: Cause of death: Father's occupation:	Mother: Living? If alive, give mother's present age: If deceased, give her age at time of death: Cause of death: Mother's occupation:
Religion:	
Education: What is the last grade completed (degree)?	

Circle any of the following that apply:

Happy childhood	School problems	Medical problems
Unhappy childhood	Family problems	Alcohol abuse
Legal trouble	Drug abuse	Strong religious convictions
Emotional/Behavioral problems	Others:	

Has your child ever been hospitalized for psychological problems? If yes, when & where:	
Has your child ever attempted suicide? If so, when?	Has any relative attempted or committed suicide?
Does any member of your family suffer from alcoholism, epilepsy, depression or anything else that might be considered a "mental disorder"?	

Analysis of Current Stress

The following section is designed to help you describe your child's current stress in greater detail and to identify problems which might otherwise go unnoticed. This will enable me to design a comprehensive treatment program and tailor it to your child's specific needs.

Circle any of the following behaviors that apply to your child:

Overeat	Suicidal attempts	Can't keep a job
Take drugs	Compulsions	Insomnia
Vomiting	Smoke	Take too many risks
Odd behavior	Withdrawal	Lazy
Drink too much	Nervous tics	Eating problems
Work too hard	Concentration difficulties	Aggressive behavior
Procrastination	Sleep disturbance	Crying
Impulsive reactions	Phobic avoidance	Outbursts of temper
Loss of control	Others:	

Are there any specific behaviors, actions or habits that you would like your child to change?

What are some special talents or skills your child feels proud of?

What would your child like to do more of?

What would you like your child to do less of?

What would you like your child to start doing?

What would you like your child to stop doing?

How is your child's free time spent?

Feelings:

Circle any of the following feelings that often apply to your child:

Angry	Guilty	Unhappy
Energetic	Annoyed	Happy
Bored	Relaxed	Sad
Conflicted	Restless	Tense
Depressed	Regretful	Lonely
Anxious	Hopeless	Contented
Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic
Others:		

What feelings would your child most like to experience more often?

What feelings would your child like to experience less often?

What are some positive feelings your child has experienced recently?

When is your child most likely to lose control of your feelings?

Describe any situations that make your child feel calm or relaxed:

Does your child have trouble relaxing and enjoying weekends and vacations? (If yes, please explain):

Physical Sensations: *Circle any of the following that often apply to your child:*

Headaches	Stomach trouble	Skin problems
Dizziness	Tics	Visual disturbances
Dry mouth	Fatigue	Hearing problems
Palpitation	Twitches	Burning or itchy skin
Muscle spasms	Flushes	Chest pains
Tension	Numbness	Back pain
Rapid heart beat	Watery eyes	Tremors
Don't like being touched	Sexual disturbances	Tingling
Excessive sweating	Unable to relax	Fainting spells
Blackouts	Bowel disturbances	Hear things
Other:		

Image: *Circle any of the following that apply to your child:*

Pleasant sexual images	Unpleasant sexual images	Aggressive images
Unpleasant childhood images	Lonely images	Images of being loved
Helpless images	Seduction images	
Other:		

I Picture Myself: Circle any of the following that apply to your child:		
being hurt	hurting others	being followed
not coping	being in charge	being laughed at
succeeding	failing	being trapped
losing control	Other:	

Thoughts: Circle each of the following thoughts that apply to your child:
I am worthless, a nobody, useless and/or unlovable.
I am unattractive, incompetent, stupid and/or undesirable.
I am evil, crazy, degenerate and/or deviant.
Life is empty, wasted; there is nothing to look forward to.
I make too many mistakes, I can't do anything right.

Circle each of the following words that your child might use to describe himself/herself:		
intelligent	confident	trustworthy
loyal	worthwhile	unattractive
confused	ambitious	considerate
worthless	useless	memory problems
full of regrets	a nobody	sensitive
attractive	morally degenerate	a deviant
crazy	unlovable	honest
inadequate	stupid	conflicted
ugly	naive	good sense of humor
incompetent	horrible thoughts	can't make decisions
concentration difficulties	suicidal ideas	persevering
hard-working	Other:	

What do you consider to be your child's most irrational thought or idea:

Friendships

Does your child make friends easily?	Does he/she you keep them?
Was your child ever bullied or severely teased?	
Circle the degree to which your child generally feels comfortable and relaxed in social situations: <p style="text-align: center;">Very relaxed Relatively comfortable Relatively uncomfortable Very anxious</p>	
Does your child have one or more friends with whom he/she feels comfortable sharing his/her most private thoughts and feelings?	

Biological Factors

Does your child have any current concerns about your physical health? Please specify:

Does your child eat three well-balanced meals each day? If not, please explain:

Does your child get regular physical exercise? If so, what type and how often?

Check any of the following that apply to your child:

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc)				

Check any of the following that apply to your child:

	Never	Rarely	Frequently	Very Often
Diarrhea				
Constipation				
Allergies				
High blood pressure				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Headache				
Backache				
Early morning awakening				
Fitful sleep				
Overeat				
Poor appetite				

Circle any of the following that apply to your child or members of your family:

thyroid disease	kidney disease	Asthma	Neurological diseases
diabetes	Cancer	Gastrointestinal disease	Prostate problems
Glaucoma	Epilepsy		

Has your child ever had any head injuries or loss of consciousness? Please give details:

Please describe any surgery your child has had (give dates):

If you wish to add any additional comments/information to this form, please feel free to do so in the space below.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices please contact:

Leah E. Neese, M.A., LPC
 P.O. Box 297
 Mont Belvieu, TX 77580
 (713) 825-0086

Effective Date of This Notice: April 14th 2003

I. How the practice may Use or Disclose Your Health Information

This practice collects health information from you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of the practice, but the information in the medical record belongs to you. The practice protects the privacy of your health information. The law permits the practice to use or disclose your health information for the following purposes:

1. Treatment: I will use the health care information I learn about you to provide you with health care services.
 - (i) The following people in my office will have access to your information:
 - a. *Medical staff – doctors, physician assistants, and nurse practitioners*
 - b. *Nursing staff – registered nurses, licensed practical nurses, and medical assistants*
 - c. *Other clinical staff – phlebotomists, laboratory technologists and technicians*
 - d. *Reception staff*
 - e. *Medical records personnel*
 - (ii) I have established standards and procedures that limit various staff members' access to your health information according to their primary job functions. These standards and procedures may change from time to time. All of my staff is required to sign a confidentiality statement.
 - (iii) I will share your health care information with other health care providers involved in your care.
 - 1) *When I admit you to the hospital, I will share your health care information with personnel of that hospital. That hospital will have a privacy and confidentiality policy like this one. If you have questions about their policy, you should ask them.*
 - 2) *When I refer you to a specialist, I will share your health care information with them. I will send this information whether you actually see the specialist (for example, a surgeon) or whether you do not (for example, if we send a specimen to a laboratory for analysis). That specialist will have a privacy and confidentiality policy like this one. If you have questions about their policy, you should ask them.*
 - 3) *When I submit laboratory specimen to reference laboratories, and/or pathologists.*
 - (iv) I will share your health care information with other people associated with your care at my office. These include:
 - 1) *Family members you involve in your care*
 - 2) *Friends you choose to include in your care*
 - 3) *Other caregivers you choose to involve in your care*
 - 4) *Other parties actively involved in your care*

2. Payment: I will use and disclose your health care information to seek reimbursement for services I Render you and members of your household. In this process, other parties may have access to the information you give me.

(i) In this context, these parties include:

- 1) *My business office staff*
- 2) *The insurance organizations involved in your care*
- 3) *An organization that mails my statements to you*
- 4) *If one is required, the collection agency I use to collect unpaid balances.*
- 5) *Other firms that become involved in the process of processing or reviewing payment activities.*

Regular Health

Care Operations: I will use and disclose your health information to keep our practice operable.

(i) Examples of this kind of personnel include, but are not limited to, the following:

- 1) *My medical records staff*
- 2) *Outside health or management reviewers*
- 3) *Individuals performing similar activities*

(ii) Governmental Oversight Activities – if I receive proper instruction from a party with applicable jurisdiction, I will use and disclose your health information to support activities associated with audits, investigations, license reviews, applications for privileges, and in compliance with governmental programs and laws.

(iii) As required by law – I will use and disclose your health care information as required by a court or administrative order, subpoena, discovery request, or other lawful process. I will use and disclose your information when requested by national security, intelligence, and other State and Federal officials, and/or if you are an inmate or otherwise under the custody of law enforcement.

(iv) For appointment reminders – I will use and disclose your health information to remind you of appointments you have made in my office or elsewhere.

(v) Treatment alternatives – I will use and disclose your health information to seek out treatment alternatives for You of which I become aware in the professional or popular literature.

(vi) Research – I will use and disclose your health information to participate in research programs that have proper governmental approval. If your information is to be presented in a format that would allow individual identification, I will seek your written authorization before disclosing it.

(vii) Upon military command – if you currently serve in the military or are a veteran, I will disclose your information upon proper military command.

(viii) To prevent a serious threat to health or safety – if I determine that there is a serious threat to the health or safety of you or some other individual, I will disclose your health information to the proper authorities.

(ix) To discharge public health responsibilities – I will disclose your health care information to report deaths, child Abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury, and disability.

4. Information provided to you: You have the right to:

Inspect and copy your health care information, or that of an individual for whom you are a legal guardian.

(i) If you wish to examine your health care information, you will need to complete and submit the form shown as Exhibit A of this policy. Additional copies are available separately.

(ii) After I receive the form, I will determine whether to permit you to examine your health care information. In some cases, I may refuse to permit you to do so. Examples of reasons why I would refuse include, but are not limited to, the following: A determination that doing so might harm you, or might harm another person.

- (iii) Unless I decide to refuse permission to review your health care information, I will make an appointment for you to review the information. You will do so in a private room, with a member of my staff available to assist you in finding information. I may charge a fee for this service.
- (iv) While reviewing the information, you will have the right to a copy of parts or all of your health care information. I may charge a fee for this service.

- (i) To request an amendment to your health care information, please request and complete the amendment form available in my office. Additional copies are available separately.
- (ii) I will review your request to amend your record. I may decide to deny the amendment. Examples of reasons why I would refuse include, but are not limited to, the following: If I feel it is false or misleading, or could harm you or some other person.
- (iii) If I accept your amendment, I will attach it as a permanent document in your health care record. If you make reference, individually and specifically, to specific documents in your health care record, I will append a note to each such document referring a future reader to your amendment. You need to describe each document individually. If you do not identify any particular documents or simply state "all" (or some similar language), then I will add your amendment as a separate document into the chart, but not append notes to any other documents.

You have the right to receive a list of non-routine disclosures we have made of your health care information.

- (i) When I refer you to a specialist as described above, I make a routine disclosure of your health care information that I think will be necessary and appropriate for treatment, payment, and health care operations. I do not keep record of these routine disclosures.
- (ii) You can request a list of non-routine disclosures of your health care information I have made. I will provide you a list of these disclosures during the subsequent six years, beginning with April 14, 2003. To request a list of these disclosures of your health care information, complete and submit the appropriate form available in my office. Additional copies are available separately.

You have the right to request a limit to the health care information we disclose about you.

- (i) If you wish to do so, write a letter describing your concerns and wishes to your physician or to my Privacy Officer.
- (ii) I am not obligated to acquiesce to your request. However, if I do agree, I will comply with your requests in all subsequent decisions to use and disclose your health care information.

You have the right to request confidential communications.

- (i) In general, I will not disclose your health care information except as described above. If, however, you wish me to restrict further the parties who will have access to your information, please request the appropriate form available from my office.
- (ii) I am not obligated to acquiesce to your request. However, if I do agree, I will comply with your requests in all subsequent decisions to use and disclose your health care information.

5. Directory. I may list your name, your general medical condition and your religious affiliation in my directory. This information may be provided to members of the clergy. This information, except your religious affiliation, may be provided to other people who ask for you by name. If you do not want me to list this information in my directory and provide it to clergy and others, you must tell us that you object.

6. Notification and communication with family. I may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, I will give you the opportunity to object prior to making this notification. If you are unable

or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Required by law. As required by law, I may use and disclose your health information.
8. Public health. As required by law, I may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
9. Health oversight activities. I may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
10. Judicial and administrative proceedings. I may disclose your health information in the course of any administrative or judicial proceeding.
11. Law enforcement. I may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
12. Deceased person information. I may disclose your health information to coroners, medical examiners and funeral directors.
13. Organ donation. I may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
14. Research. I may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or the privacy board.
15. Public safety. I may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Specialized government functions. I may disclose your health information for military, national security, prisoner and government benefits (only for health plans) purposes.
17. Worker's compensation. I may disclose your health information as necessary to comply with worker's compensation laws.
18. Marketing. I may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
19. Fund-raising. I may contact you to participate in fund-raising activities.
20. Change of Ownership. In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When the practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this practice will not use or disclose your health information without your written authorization. If you do authorize this practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, this practice is required by law to comply with this Notice.

IV. Complaints

You have the right to file a complaint with us about my adherence to these policies.

- (i) Your complaint should be directed to my Privacy Officer.
- (ii) You can either write a letter addressed to the Privacy Officer, or complete and submit the appropriate form available from our office. Additional copies are available separately.

You have the right to file a complaint with the Secretary of Health and Human Services.

- (i) You should write a letter describing your concerns.

(ii) The letter should be addressed as follows:

Secretary of Health and Human Services
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Consent for the Use or Disclosure of Protected Health Information

Leah E. Neese, M.A., LPC
P.O. Box 297
Mont Belvieu, TX 77580
(713) 825-0086

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Signature _____ Date _____

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

Signature Date

REVIEWER SECTION

The terms of this request are / are not (circle one) acceptable.

Signature Date

Privacy/Security Committee Members

Leah E. Neese, M.A., LPC

Reviewer's comments:

REVOCACTION SECTION

I hereby revoke this consent.

Signature Date

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Mont Belvieu, TX 77580
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www.montbelvieu counseling.com

Informed Consent/Counseling Policies and Procedures/Authorization for Services

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services, and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

Counseling Process: Counseling (Burks & Steffle, 1979) can be defined as a “professional relationship between a trained counselor and a client...It is designed to help clients to understand and clarify their views of their lifespan, and to learn to reach their self-determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature.”

The primary purpose of counseling is to create changes in mood, attitudes, behavior, thoughts and feelings that have prevented the client from enjoying life and realizing his/her potential. Counseling involves sharing sensitive, personal, and private information that may, at times, be distressing. During the course of counseling, clients often experience periods of anxiety or confusion. Counseling is best accomplished when it is a combined effort between the counselor and client. Talking with a counselor, alone, does not guarantee success or progress. The level of satisfaction for a particular individual is not predictable.

Ms. Neese will respect each client as an individual and convey this respect by keeping appointments or contacting the client to reschedule, if necessary, giving the client complete attention during sessions, avoiding interruptions during sessions, and providing the client with the most effective counseling possible.

Sessions will be documented in writing. Only information considered critical to the counseling situation is maintained as part of the counseling record. Ms. Neese is required by law to maintain client records for a period of seven (7) years.

Confidentiality: ALL discussions with Ms. Neese will remain confidential. Ms. Neese will not give out any information about you to your employer, parents, friends, or others without your written permission except in circumstances described below. If you are under eighteen (18) years of age, Ms. Neese reserves the right to advise your parent(s) or legal guardian about developments that could significantly affect your health or well-being. In such situations, the contents of specific meetings between you and Ms. Neese will not be discussed, but your overall progress may be discussed in general terms.

Exceptions to Confidentiality: There are certain, specific situations in which your confidentiality is overridden. Ms. Neese is required by law to report any statements of child or elderly abuse or neglect to the appropriate authorities. Further, if you make statements that indicate you intend to harm yourself or others, Ms. Neese is required by law to notify medical and/or law enforcement. If you are involved in a criminal case, a judge may order Ms. Neese to turn over your file to the court.

You must give signed permission before Ms. Neese can share any facet of your counseling with anyone. If you give Ms. Neese written permission, you will have the right to designate who should receive information from your file, what information they are allowed to receive, the intention for which they will use the information and the period of time during which you are granting the permission. Examples of circumstances requiring a release of information include: certain inquiries from insurance companies, a new counselor wanting to use records from a previous counselor to provide continuing care, and collaboration with another agency or professional in your treatment. Ms. Neese may consult and seek supervision with a mental health professional regarding your assessment and care. This consultation is free of charge to you. Any identifying information (to protect confidentiality) will not be revealed. All consultants are legally bound to maintain confidentiality.

Counseling a Minor: The information obtained from a minor through the provision of counseling is confidential and will not be shared without the written consent of the minor's parent(s) or legal guardian except for the following reasons: a). there is an imminent danger to your child; b). your child reveals information about mental or physical abuse; and, c). A court orders the counselor to release the information. Information contained in your child's records will not be released to a third party other than in circumstances described above unless you give written consent for release.

Referrals: There are some mental health-related services that Ms. Neese may be unable to provide. In these cases, Ms. Neese assists clients with referrals. The referral process often requires sharing of information and completion of paperwork.

Payment Policy: Payment is due at the beginning of each session. Ms. Neese's fee is \$90.00/hour for Individual Therapy and \$100.00/hour for Couples and Family Therapy, and must be paid by the client at the onset of each session. On a case by case basis, Ms. Neese will provide in-home counseling at a rate of \$200/hour. If Ms. Neese is considered an out-of-network health care provider by your insurance company, she will provide you with the proper information and information to submit to your health insurance company. If Ms. Neese is considered an "in-network" provider, your deductible payment is due to Ms. Neese at the onset of each session, and Ms. Neese will subsequently submit the proper paperwork to your insurance company. If more than three (3) consecutive sessions have occurred without payment, termination or referral of services may be considered, and will be discussed with the client.

Phone Consultation: After the first ten (10) minutes of phone consultation, clients are billed \$20.00 per ten (10) minutes. After the first ten (10) minutes, clients are billed a minimum of \$20.00. Immediate payment is required. Please see the examples below:

Example A: Thirty (30) minute phone consultation

First ten (10) minutes = free of charge

Twenty (20) minutes of phone consultation = \$40.00

Example B: Forty-five (45) minute phone consultation

First ten (10) minutes = free of charge

Thirty-five (35) minutes of phone consultation = \$70.00

Subpoenas and Court Costs: Ms. Neese’s retainer for attending court (with or without a subpoena) is \$500.00. Subsequent fees are \$200 an hour (including travel time) plus any other expenses incurred (i.e., gas, airfare, car rental, hotel).

Cancellation Policy: Cancellation of an existing appointment must be made at least twenty-four (24) hours in advance. If the appointment is canceled less than 24 hours before the scheduled time, the client will be billed \$90.00 for an individual therapy and \$100 for a couples/family therapy. Furthermore, if Ms. Neese is not contacted to reschedule or cancel an appointment (at any time), she will make at least two attempts to contact the client. Subsequently, a Termination of Services letter and \$90.00 invoice (for the missed appointment) will be mailed to the client. Please be aware that most if not all insurance companies do not reimburse for “no-show” or canceled appointments, and the client will be responsible for the full amount. Unforeseen or emergency situations will be taken under consideration. By engaging in the counseling process, I understand and commit to the activities and policies outlined in this document.

By signing below, I affirm that I have read and discussed the information herein with Ms. Neese. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and my responsibility as a client.

Leah E. Neese, M.A., LPC

Date

Client Signature or Parent Signature
if client is under 18 years-old

Date

Print Name

Mont Belvieu Counseling

Leah E. Neese, M.A., LPC

P.O. Box 297

Mont Belvieu, TX 77580

(713) 825-0086

www.montbelvieu counseling.com

Credit Card Authorization Form

I, _____, hereby authorize Leah E. Neese, M.A., LPC to bill my credit card as listed below for professional fees for [] myself or _____.

I agree that Leah E. Neese, M.A., LPC may bill my credit card at the full fee of \$90.00 (Individual)/ \$100.00 (Couples and Families) for professional services including the following:

(Initial)

_____ Appointments that I elect to pay by credit card.

_____ Missed appointments. (Will be charged at the full fee)

_____ Appointments I have cancelled with less than 24 hours' notice. (Full fee)

I also agree that my credit card may be charged for the following:

_____ Balances of charges not paid by me or my insurance.

_____ Insufficient funds/returned checks and bank charges for those.

Type of Card: (check one):

Visa Mastercard Discover American Express

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____

CVV2/CID Security Code: _____

Zip code on billing address: _____

Signature: _____

Date of Signature: _____

Charges will appear on your credit card statement as Leah E. Neese, M.A., LPC or some variation of it.