ALLEN COUNSELING GROUP, PLLC
Tami V. Allen, M.S., LPC
5959 West Loop S., Suite 367
Bellaire, Texas 77401

CONSENT FOR SERVICES

Client's Name: _____ Date of Birth: _____

I _____, hereby give full consent for myself (or my child) to receive services of Tami Vienn Allen, MS, LPC until I notify her or she determines services are no longer appropriate or will no longer be provided. I understand my first session with Tami Vienn Allen, MS, LPC is a consultation only. This consultation is for an evaluation of my (or my child's) mental health. It may take more than one session to complete the evaluation. I understand formal treatment is not initiated until Tami Vienn Allen, MS, LPC and I agree to do so.

I authorize Tami Vienn Allen, MS, LPC to carry out the psychological assessments and treatment which are advisable during the course of my psychotherapy. I understand that while the assessment and treatment is designed to be helpful and beneficial, it may at times be difficult and uncomfortable. There is an expectation that I (or my child) will benefit from the assessment, but there is no guarantee this will occur. I also understand that the nature of psychotherapeutic treatment includes the possibility that symptoms may worsen before improving, and that there is no guarantee of a cure.

Benefits and Risks

Psychological services have both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, such work has been shown to have benefits for individuals who undertake it. Therapy and other psychological services often lead to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy and other psychological services require a very active effort on your part. In order to be most successful, you will have to work issues discussed outside of sessions.

Therapist's Incapacity or Death:

In the event your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give consent to allow another licensed mental health professional selected by your therapist to take possession of your records and provide copies upon your request, or to deliver them to a therapist of your choice.

Termination of Treatment

I understand the length of time required for therapy will be determined by my personal situation. I understand Tami Vienn Allen, MS, LPC, will do her best to fulfill my therapeutic needs and to provide me with her best professional care. For my part, I agree to participate in the process to the best of my ability. It is intended that when my needs are met, to the extent that they can be, we will terminate our relationship.

I understand for my part, I may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing me verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations.

I understand Tami Vienn Allen, MS, LPC will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with her. My signature on this consent form verifies I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Tami Vienn Allen, MS, LPC, and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

Non-Voluntarily Discharge from Treatment

Services with Tami Vienn Allen, MS, LPC may be terminated non-voluntarily, if: **(A)** the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts on-site, and/or **(B)** the client refuses to comply with stipulated practice rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with Tami Vienn Allen, MS, LPC (owner) or request to reapply for services at a later date.

Contacting Your Service Provider

Tami Vienn Allen, MS, LPC can be contacted by phone at (713)597-4499. Messages are reviewed daily and calls will be returned by the end of the business day, 12pm the following business day. Please note that calls are not answered during therapy sessions. You may contact Tami Vienn Allen, MS, LPC via email on a nonemergent basis at Tami@AllenCounselingGroup.com. If, for any reason, you are experiencing a mental health crisis and your call or email is not returned, or you cannot be reached, **please call 911** or go to the nearest hospital emergency room.

Tami Vienn Allen, MS, LPC will inform you in advance of planned absences and make provisions for rescheduling your appointment upon her return. If you experience an emergency during these times, **please call 911** or go to the nearest hospital emergency room.

Email and Texting Consent

HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to do so. Email is a very convenient way to handle administrative issues like scheduling or receipt requests, but email is not 100% secure. Some of the potential risks you might encounter if we email include:

- Mis-delivery of email to an incorrectly typed address.
- Email accounts can be 'hacked,' giving a 3rdparty access to email content and addresses.
- Email providers (i.e., Gmail, Comcast, and Yahoo) keep a copy of each email on their servers, where it might be accessible to employees, etc.

For these reasons, no form of technology will be used to discuss clinical matters and is strictly to communicated administrative matters. Please indicate how you prefer to receive the following:

Scheduling/appointment reminders: __Text __Email __ Phone Contact: _____
Billing Statements: ___In person ___ Email: _____
General messages: ___Text ___Email ___Phone Contact: _____

This consistent will remain in effect until/unless requested to cancel and notified in writing to Allen Counseling Group, PLLC.

Additional Rights

If you are unhappy with what is happening in therapy, please talk with Ms. Allen about your concerns. Such comments will be taken seriously and handled with respect and professionalism. You have the right to receive services in a private, safe and respectful environment without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects the provision of services and my education and experience.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Client/Parent Name (Printed)

_____

Client/Parent/LAR Signature Date

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact Allen Counseling Group, PLLC. You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

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Bellaire, Tx 77401
713-597-4499

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NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' personal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know Allen Counseling Group, PLLC is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

Allen Counseling Group, PLLC protects your health information by treating all of your health information that she collects as confidential (for exceptions to confidentiality see Consent for Treatment), by training all staff in federal and state confidentiality policies and practices per HIPAA, by restricting access to your health information only to those office staff that needs to know your health information in order to provide her services to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Allen Counseling Group, PLLC may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.

Clarification of terms:

PHI- information in your health record that could identify you.

Treatment, Payment, and Health Care Operations

Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.

Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations – are activities that relate to the performance and operation of our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.

Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other
parties.

Uses and Disclosures Requiring Authorization

Allen Counseling Group, PLLC and any administrators of her may use or disclose PHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information. Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The laws allow Allen Counseling Group, PLLC use or disclose PHI without your consent or authorization in some cases. Here are some examples of when this might occur:
When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the
provider receives a subpoena, discovery request, or other lawful process, some of your PHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.
For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to
investigate a crime or criminal.
For Public Health Activities – Some of your PHI might be disclosed to agencies which investigate diseases or injuries.
Relating to Decedents – PHI might be disclosed to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.
For Specific Government Functions – PHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.
To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI. This disclosure will only be provided to persons who can prevent the danger.
Therapist's Incapacity or Death – In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records.

Patient Rights and Provider's Duties

Patient Rights:
Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. Allen Counseling Group, PLL may not be able to accept your
request; however, if accepted she will uphold it except in case of emergency or if it is against the law.
Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.

Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be
amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. If your health information is
disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of Allen Counseling Group, PLLC

Provider is required by law to maintain the privacy of PHI and to provide you with this notice of legal duties and privacy practices. Allen Counseling Group, PLLC reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. She reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Confidentiality

I understand Tami Vienn Allen, MS, LPC regards the information I share with her as most confidential, and that she honors my right to privacy. I understand she adheres to what she believes to be a much more stringent set of confidentiality guidelines than those provided by the State of Texas or the federal department of Health and Human Services. Specifically, I understand Tami Vienn Allen, MS, LPC is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to the situations listed below:
1) If I am evaluated to be a danger to myself or others;
2) If I am a minor, elderly, or disabled person and Tami Vienn Allen, MS, LPC believes that I am the victim of abuse
or if I divulge information about such abuse;
3) If I divulge information which would cause Tami Vienn Allen, MS, LPC to reasonably believe that I have abused or neglected a minor, an elderly or disabled person, or a member of another protected class;
4) If I file a suit against Tami Vienn Allen, MS, LPC for malpractice;
5) If a court order, other legal proceedings, or statute requires disclosure;
6) If the patient is a minor, parents have access to medical records unless limited by court order;
7) If Tami Vienn Allen, MS, LPC is required to report certain professional ethical situations she will abide by Texas
laws;
8) I further acknowledge that a third-party payer may have limited access to otherwise confidential information.

Should disclosure be necessary, Tami Vienn Allen, MS, LPC will make every reasonable effort to inform me of the disclosure. If the course of therapy reveals any intent to harm either myself or others, I acknowledge Tami Vienn Allen, MS, LPC legal and moral duty to prevent me from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If I reveal an intent to harm myself, Tami Vienn Allen, MS, LPC has my permission, also irrevocable, to prevent me from accomplishing my intent.

Records

I understand it is stated law that mental health professionals maintain a record of the treatment given to me. This record will contain the information that will allow Tami Vienn Allen, MS, LPC to chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I
may get a copy of the file only by providing her with a signed release of information request. Tami Vienn Allen, MS, LPC may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I
will pay the administrative fees in advance for the time required for the preparation of the treatment summary and the cost of copying the records. This included providing copies or reports to any court or legal representative or designate. In the event of your death, these requirements will be binding on any heirs, successors or executor(s).

If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree Tami Vienn Allen, MS, LPC may synopsize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If I have been referred to this practice by a managed care or insurance company, or I plan to request Tami Vienn Allen, MS, LPC, file for reimbursement with a managed care or insurance company, I am aware that she may have to waive my right to confidentiality as it pertains to in the managed care or insurance company. If she is an approved provider, she may have to share all the information I provide with this organization. I understand Tami Vienn Allen, MS, LPC, will do so as required to get me all the treatment that is appropriate. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Tami Vienn Allen, MS, LPC, cannot guarantee their continued confidentiality.

Consent for the Use or Disclosure of Health Information for Treatment, Payment, or Health Care Operations

In my notice of Privacy Practices, I provide you with information about I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_____

Client/Parent Name (Printed)

_____

Client/Parent/LAR Signature Date

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CLIENT REGISTRATION PAGE

PERSONAL INFORMATION

Client Name: _____ DOB: _____
SS#: _____ DL#: _____ State: _____
Marital Status: __SINGLE _ _MARRIED __DIVORCED __ WIDOWED __SEPARATED __ DOMESTIC PARTNER
Address _____ APT#: _____
City: _____ State: _____ Zip: _____
Email: _____ Work: _____ Cell: _____

Spouse/Significant Other/Guardian_____ DOB: _____
Email: _____ Cell: _____ Anniversary: _____
Responsible for payment: _____ **Signature:** _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Home: _____ Work: _____ Cell: _____
PCP: _____ Phone: _____

EMPLOYMENT

Employer: _____ Occupation: _____
Spouse Employer: _____ Occupation: _____

INSURANCE INFORMATION - Policy Holder Information

Insurance Company Information -- PRIMARY COVERAGE

Policy holder Name_____ M.I._____ Last Name: _____
Address _____Apt: _____
City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell phone _____

Birth Date _______________ Gender: _____
Client relationship to Insured: Self Spouse Child Other: _____
Under employer's health plan? *Circle one* Y N Insured's Social Security # _____
Employer Name_____ Phone #: _____
Ins Co. Name_____ Plan name: _____Phone number _____
Address_____ City_____ State_____ Zip_____
Plan ID number _____ Group number_____

Insurance Company Information -- *SECONDARY COVERAGE*

Policy holder Name_____ M.I._____ Last Name: _____
Address _____Apt: _____
City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell phone _____

Birth Date _______________ Gender: _____
Client relationship to Insured: Self Spouse Child Other: _____
Under employer's health plan? *Circle one* Y N Insured's Social Security # _____
Employer Name_____ Phone #: _____
Ins Co. Name_____ Plan name: _____Phone number _____
Address_____ City_____ State_____ Zip_____
Plan ID number _____ Group number_____

FAMILY HISTORY

Please list family members who live in the home with you and their ages.

_____ _____
_____ _____
_____ _____
_____ _____

Are there any children who live elsewhere? Please list their names, ages, and reason for moving out.

_____

Does either parent travel frequently? How often? _____
Has there been a divorce in the family? If so, when? If there are children, what are the custody arrangements? _____
_____

Are there any other family members who are very actively involved in your family life? If so, who? _____
_____

Current Stressors

Have you experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your own
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leave home
- ☐ Conflict with in-laws
- ☐ Change in job - new position, new company, laid off, retired, quit
- ☐ Change in financial status, either more or less money
- ☐ Change in daily responsibilities

□ Change in social network
□ New marriage in the family
□ Outstanding personal achievements
□ Other: _____

MEDICAL HISTORY

Do you have any of the following medical problems?

Current	Past		Current	Past	
□	□	Heart Problems	□	□	Head Injury
□	□	Digestive Problems	□	□	Surgeries
□	□	Hypothyroidism	□	□	Tics
□	□	Hyperthyroidism	□	□	High Blood Pressure
□	□	Diabetes, Type I	□	□	Reproductive Problems
□	□	Diabetes, Type II	□	□	PMS symptoms
□	□	Overweight	□	□	Muscle tension
□	□	Underweight	□	□	Headaches
□	□	Back or neck pain	□	□	Cancer

Primary Care MD treating you: _____ Phone #: _____
For what conditions: _____
Psychiatrist treating you: _____ Phone #: _____
For what conditions: _____
Other physicians treating you: _____ Phone #: _____
Current physical problems (describe): _____
Current Medications: _____
Are there any other medical problems not listed above that you experience? _____
_____

Recreation

How do you spend your "free time"? _____
_____
Please check the following activities that you engaged in the last month.
□ Exercise, how often? _____
□ Out with friends, how often? _____
□ Out with spouse, how often? _____
□ Relax, how often? _____
□ Took time to yourself, often? _____
□ Enjoyed something lately? _____

MENTAL HEALTH HISTORY

What problems are you struggling with that have brought you here today? _____
_____
Have you sought psychotherapy before? If so, what were the circumstances? _____
_____
Did you find therapy helpful? _____
Are you currently, or have you ever, taken any medications to help with any mental health problems? If so, please list. _____

Did you (or do you) find the medication helpful? _____
What do you hope to gain out of therapy? What changes do you hope to make? _____
_____
Have you previously received a mental health diagnosis? _____
_____
Have you ever been hospitalized for mental health concerns? Yes____ No____
For what Diagnosis: _____
Are you currently preoccupied with suicidal or homicidal thoughts? Yes____ No____
Have you ever made any attempt to commit suicide or homicide? Yes____ No____
If yes, please specify: _____
Any history of self-harm behavior? __No __Yes, what behavior? _____

Have you or any of your family members struggled with any of the following problems?

	Self Present or Past?	Date Symptoms First Started	Parent, Mom or Dad?	Sibling	Child	Spouse
Depression, sadness, hopelessness, guilt						
Anxiety, Excessive Worries						
Panic Attacks, Racing thoughts, Rapid heartbeat, Shortness of breath						
Obsessions and/or Compulsions						
Suicidal or Homicidal Thoughts						
Attempted Suicide						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositional/Defiance						
Schizophrenia or Psychosis (Auditory or Visual Hallucinations)						
Nervous Breakdown						
Heavy Alcohol Use						
Drug use/abuse						
Eating Disorder						
Abuse – Emotional, Verbal, Mental, Physical, or Sexual						
Post-Traumatic Stress						
Isolation/Withdrawal						
Trouble Sleeping						
Trouble with Appetite						
Sudden changes in weight: Increase/decrease						
Victim of Bullying						
Cigarettes						
Other:						

FINANCIAL FEES and POLICY

SELF-PAY/ OUT OF NETWORK:		Fee:	Session Length:
Initial Intake Evaluation –	Individual	$185	75-minute session
	Couple	$225	
Psychotherapy	Individual	$140	50-minute session
	Couple	$175	
		$50/$75	additional 25 minutes
Group Psychotherapy		$40	per session
Mediation		$375	per party/ per 4 hours

*****INSURANCE DOES NOT REIMBURSE FOR COUPLES COUNSELING*****

Payment methods include check, cash, or credit card at the time of session. Returned checks due to NSF are subject to a $35.00 fee. Allen Counseling Group, PLLC reserves the right to use an attorney and/or collection agency to recover payment as agreed. Allen Counseling Group revisits fee structure twice per year and will provide at least 6-week notice of any changes in fees and/or insurance network status.

In-Network Benefits

Allen Counseling Group, PLLC will make every attempt to obtain accurate and up-to-date insurance, however, information reported to us is not a guarantee of benefits, and benefits are subject to change at any time. We will work under the assumption that the following terms are applicable per verification of your benefits until you notify us of a change. Should we be informed by the insurance company for non-payment of services or changes in the plan benefits, you will be notified as soon as possible and be required to reimburse Tami Vienn Allen, MS, LPC/Allen Counseling Group, PLLC for all unpaid charges and outstanding balances within 14 days. If/when you acquire new insurance, we require a 48 HOUR NOTICE prior to your scheduled appointment. If you do not provide your updated insurance information within the 48-hour timeframe you will be subject to a fee. The fee will be based on the contracted rate of your insurance company.

Allen Counseling Group, PLLC will make a maximum of TWO attempts to collect payment from your insurance company. If unsuccessful, payment in full will be required and *you* will be provided with a receipt to submit to your insurance for re-imbursement. Balances must be brought current and paid in full at the beginning of every month before moving forward with services.

Your signature below indicates that you have read and agree to the terms of the Financial and Missed Appointments Policy and you understand that you will be responsible for any fees and/or balances owed on your account if you do not provide your new insurance information within 48 hours prior to your scheduled appointment. This includes claims that are denied.

MISSED APPOINTMENTS

Therapy sessions will ordinarily be 45-60 minutes, once a week, though some sessions may be more or less frequent based on your needs. Should you have to cancel a therapy session, ***please contact the office by 2pm the previous business day to avoid a $100 late-cancellation/no-show fee*** so your appointment time can be offered to another client. This fee will be charged to the credit card on file and is not reimbursable by insurance. If you are unable to make your scheduled appointment, I will make every effort to find another time to reschedule the appointment. In addition, ***you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.***

_____ _____

Client/Parent Name (Printed) Signature Date

REFERRED BY:

__ Medical Provider: _____

__Family/Friend: _____

__Insurance Provider Co: _____

__Internet Search: _____

__Other: _____

___Psychology Today ___Good Therapy ___ACG Website ____ Therapy for Black Girls

To be Completed by Therapist

CREDIT/DEBIT CARD:

Name as Appears on Card: _____

Visa MC Amex Discover CC#: _____ Exp: _____CVV: _____

I _____ understand that by providing my Credit Card information I am consenting to being financially responsible for _____ regarding any and all professionally fees for rendered services as per the Financial Policy**. I give permission to Allen Counseling Group, PLLC to charge the above credit card on file for professional counseling and administrative services to satisfy any/all balances on my account.** Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Printed Name of Cardholder: _____

Signature of Cardholder: _____ Date: _____