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Alamo Heights Forensic and Individual Therapy
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CLIENT INFORMATION

If a Child is the Client, Use the Child's Information. DATE: _____

CLIENT NAME: _____
First Middle Last

AGE: _____ DOB: _____ SOCIAL SECURITY #: _____

DRIVER'S LICENSE #: _____

HOME ADDRESS: _____
Number/Street City State Zip Code

HOME PHONE: _____ WORK PHONE: _____
May we call you here? Y N May we call you here? Y N

EMPLOYER/SCHOOL: _____ E-MAIL ADDRESS: _____

CURRENT MEDICATIONS:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

WHO PRESCRIBES YOUR MEDICATION:
_____

CHRONIC HEALTH CONDITIONS:
_____

REASON FOR THIS REFERRAL:
_____
_____

PREVIOUS THERAPY OR EVALUATIONS:
_____
_____

RESPONSIBLE PARTY (If Different From Above)

NAME: _____ DOB: _____ SS #: _____

DRIVER'S LICENSE #: _____ E-MAIL: _____

RELATIONSHIP TO CLIENT: _____ EMPLOYER: _____

HOME ADDRESS: _____
Number/Street City State Zip Code

HOME PHONE: _____ WORK PHONE: _____
May we call you here? Y N May we call you here? Y N

IN CASE OF EMERGENCY NOTIFY (if other than above)

NAME: _____ HOME PHONE: _____

RELATIONSHIP TO CLIENT: _____ WORK PHONE: _____

Consent for Treatment

I authorize/request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and I.

_____ _____
Client/ Responsible Party Signature Date

Consent for Treatment for Child or Dependent

I am the legal guardian or legal representative of the patient and on the patient's, behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Client Name Client Social Security Number

_____ _____
Signature of Legal Guardian/Representative Date

_____
Relationship to Client

Services

Counseling $175 Per Hour
Parent Facilitation $200 Per Hour
Court Appearances $600 Initial Deposit and $200 Per Hour

Payment Terms

Payment In-Full for Services is Expected at the Time of Service. I do not accept insurance. I do not assist in filling out insurance claim forms. If requested, you will receive an itemized statement for you to send to your insurance company. This statement should be attached to one of your health claim forms and forwarded to your insurance company.

Court Ordered Procedures or Consultation You will be responsible for all the costs as decreed in the Order from the Court or in the Rule 11 Agreement signed by your attorneys.

Cancellation and Missed Appointment Policy
Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 48 hours notice, you will be billed according to the scheduled fee policy. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

Payment Terms for Court Appearances
Court Appearances/ Testimony require a minimum $600 initial retainer and $200 per hour (portal to portal). ***Court Appearance/Testimony deposits are non-refundable and shall apply to a specific scheduled court date, which is not cancelled 48 hours in advance. The therapist reserves this time specifically for you and your case.*** Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

Payment Terms for Consultation/Testimony by Phone
In the event that the therapist is requested to consult/testify in a non-court setting (example: Mediation), a fee of $300.00 will be billed. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

Fees and Billing
Fees are set for additional professional services at a prorated schedule. These services include report writing, telephone consultations, consulting with other professionals, preparation of records, treatment summaries, and time performing other services you may request/require.

Payment Terms for Preparation/Production of Documents
Preparation of correspondence and production of documents shall be billed at the rate of $175.00 per hour. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

Payment Terms for Phone Calls, Emails and Text Messages
Telephone calls, emails, and text messages will be charged at the rate of $25 per 10-minute increments. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

Office Policy

No Recording/Photography
There is no audio/video recording or photography allowed at any time; this includes all session areas and waiting areas. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date

No Food/Drink
There is no food or drink allowed; this includes all session areas and waiting areas. Your signature below indicates you have read and understand this notice.

_____ _____
Client/ Responsible Party Signature Date