Kelly Bernstein, MS, LCDC, LPC
Alamo Heights Forensic and Individual Therapy
1600 North East Loop 410, Suite 112
San Antonio, Texas 78209
Office: (210) 265-1952 Fax: (210) 267-1653
kelly@alamoforensic.com

CLIENT INFORMATION

CHILD INFORMATION, IF APPLICABLE 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: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

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: _____

Consent for Treatment

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

_____ _____

Client/ Responsible Party Signature Date

Consent for Treatment for Child or Dependent

It is essential that the ***legal custodian*** of the child/dependent grant permission for the services. If you are a divorced parent, stepparent, grandparent, guardian, or other, you may be asked to provide a copy of the court order which names you as the legal custodian of the child/ dependent.

I am the legal guardian or legal representative of the patient and on behalf of the patient, legally authorize Kelly Bernstein, MS, LCDC, LPC 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.

_____ _____

Name of Child/ Dependent Date of Birth

_____ _____

Name of Legal Guardian/Representative Relationship to Child/ Dependent

_____ _____

Signature of Legal Guardian/Representative Date

Services

Counseling - $200 Per Hour
Parent Facilitation - $250 Per Hour
Guardian Ad Litem - $250 Per Hour
Case Management - $250 Per Hour
Court Appearances - $600 Initial Deposit (Covers First 2 Hours), Then $300 Per Additional 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.

Payment Method
All clients are required to keep a current, active, unlocked credit card on file for billing purposes. If the client does not or cannot supply a credit card on file, they will ***instead*** provide a $2000 retainer.

_____ _____
Client/ Responsible Party Signature Date

Cancellation and Missed Appointment Policy
Scheduled appointment times are reserved especially for you. If an appointment is missed, rescheduled, moved, or cancelled with less than 48 hours notice ***(regardless of reason)***, 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 (covers first 2 hours), then $300 per hour (door to door). ***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
If 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

Sessions are typically scheduled for one hour. This includes 45 minutes of session time and 15 minutes for documentation and scheduling.

Fees and Billing
Fees are set for additional professional services at a prorated schedule. These services include document review, 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 $200.00 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, lengthy voice messages, text messages, and emails, will be charged at the rate of $20 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