Lazaro Counseling Center, LLC
Confidential Client Information

Please print legibly

Client information:

Client's Name:_____ DOB:_____ Age: _____Sex:___ Today's date:_____

Address:_____
Street or P.O. Box City State Zip Code

Home Phone: (____)_____Cell Phone: (____)_____Email address_____

Client's Social Security #:_____ Driver's License:_____

Race (Optional):_____ Religion (Optional):_____

Family Doctor:_____ Who referred you?:_____

Employer_____ Occupation:_____

Work Address:_____
Street or P.O. Box City State Zip Code

Work Phone: (____)_____

Legal Guardian information:

Name: _____Relationship to patient: _____

Address (if different from patient):_____
Street or P.O. Box City State Zip Code

Home Phone: (____)_____Cell Phone: (____)_____Email address_____

Legal Guardian's Social Security #:_____ Driver's License:_____

Employer_____ Occupation:_____

Work Address:_____
Street or P.O. Box City State Zip Code

Work Phone: (____)_____

Emergency contact:

Name:_____ Relationship to patient: _____

Address:_____
Street or P.O. Box City State Zip Code

Home Phone: (____)_____Cell Phone: (____)_____Work Phone: (____)_____

Lazaro Counseling Center, LLC
Financial and Insurance Information

Responsible Party Information:

Person financially responsible for this acct:_____Relationship to patient: _____

Address (if different from patient):_____
Street or P.O. Box City State Zip Code

Home Phone: (____)_____Cell Phone: (____)_____Email address_____

Employer_____ Occupation:_____

Work Address:_____
Street or P.O. Box City State Zip Code

Work Phone: (____)_____

Insurance Information:

Primary Insurance

Subscriber's Name:_____ Subscriber's birth date: _____ ___

Subscriber's Social Security #:_____ Driver's License:_____

Policy or Subscriber Number:_____ Group Number:_____

Subscriber's Address: (if different from patient):_____
Street or P.O. Box City State Zip Code

Home Phone: (____)_____Cell Phone: (____)_____Email address_____

Employer_____ Occupation:_____

Work Address:_____
Street or P.O. Box City State Zip Code

Work Phone: (____)_____

Name of Insurance Company_____Phone: (____)_____

Secondary Insurance

Subscriber's Name:_____ Subscriber's birth date: _____ ___

Subscriber's Social Security #:_____ Driver's License:_____

Policy or Subscriber Number:_____ Group Number:_____

Name of Insurance Company_____Phone: (____)_____

I authorize this office to release any information necessary to expedite insurance reimbursement, including keeping this signature on file to be used when my provider fills out the health insurance claim forms. I further understand that is it my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance company. I authorize direct payment to my service provider.

Client, Parent, or Guardian's signature:_____ Date: _____

Lazaro Counseling Center, LLC
Service Agreement

Welcome to my practice. This document contains important information about my professional services and office policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operation. HIPAA also requires me to provide you with a copy of Notice of Privacy Practices (Notice) for the use and disclosure of PHI for treatment, payment, and healthcare operations. A copy of the Notice will be provided to you from my office if you need additional information. The law also requires me to obtain your signature to acknowledge that you have been provided with this information.

Please read over this document carefully. Once signed, it represents an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding on me unless I have taken action in reliance on it: if there are requirements imposed on me by your insurance company in order to process or substantiate claims made under your policy; or if you have not settled any financial obligations you have incurred.

Psychological Services

Psychotherapy is process between the client and the therapist which depends partly on the personalities of the two parties, the particular problem you are experiencing, level of motivation to change, and other life circumstances such as interactions with family, friends, and others. Unlike a medical doctor's visit, therapy requires very active effort on your part. In order for the process of therapy to be effective, you will have to work on the things that we talk about during sessions as well as at home. I often give homework assignments. Completion of these assignments between sessions will help your therapy be more effective.

The process of therapy can also have both benefits and risks. Because therapy often requires talking about unpleasant, and sometimes painful aspects of your life, you may experience an increase in negative emotional states. In addition, there may also be increased stress in relationships. Although no guarantees can be made, therapy often results in better relationships, resolution of specific problems and unhealthy behaviors, and a reduction in the feelings of distress.

Since therapy involves a great deal of time, money and energy, you should feel comfortable with me and my manner of conducting therapy. If you have any problems or concerns about my procedures, I do expect that you will bring them up with me during the session so that we may resolve the issue before it hinders your treatment. If your problem or concern persists, then I will be happy to help you set up a meeting with another mental health professional.

Appointments:

A therapy "hour" consists of one **50 minute session**. The additional 10 minutes are reserved to finish up my notes and record keeping, and to get ready for the next client. Although I will be aware of the time, I also ask that you be cognizant of this. I will make every effort to be on time, so to get the most of your session you should also plan to arrive for your sessions in a timely manner. An appointment will be scheduled in a weekly or every other week interval depending on your needs.

Unlike doctors or dentists who routinely schedules many patients during the hour, therapists do not. Once scheduled, your time is reserved only for you. **If you cannot make an appointment, you will be expected to give a 24 business hour advanced notice of your intention to cancel or you will be charged a missed appointment fee of the allowable rate set by your insurance. Please note that insurance companies do not pay for missed or cancelled appointments thus this cost will be incurred by you.**

If you miss an appointment, I will call you to determine if you wish to continue with treatment so that you don't incur another Late Cancel/Missed appointment fee. If you miss two consecutive sessions, I will assume that you wish to terminate therapy. At this time you will be taken out of your standing appointment time slot. Once taken out of the schedule, I cannot guarantee that time slot if you wish to come back.

Professional Fees:

Unless you have insurance or we have agreed on another specified amount, my hourly rate is $250.00 for the initial session and $190.00 for sessions, thereafter. In addition to weekly sessions, I charge this amount for other professional services you may need and will break down this hourly cost if I work for periods of less than one hour. Other services which may include report writing, telephone consultations , consulting with other professional (if you have signed a consent), preparation of other records, and/or writing treatment summaries will be charged at the rate of $45.00 per quarter hour increments. Insurances do not pay for these additional services. Payment for sessions is expected in the form of a check or cash and should be paid at the time of service. I would appreciate it if you had your payment ready prior to the start of your session so that the end of the session may be concluded more efficiently. There is a $25.00 fee for returned checks. In addition, if your account goes to collections, then 45% of the amount to be collected will be added to your bill. All fees are subject to periodic adjustments.

If you get involved in any legal proceedings in the future that require my participation, you will be expected to pay for all my professional time, including preparation, travel time, and hourly cost for the appointments that I had to cancel in order to make time for court, even if I am called to testify for another party. Because of the difficulties with legal involvement and because one can never be sure of how long the court process will last, my fee is $3000.00 per day. A deposit of the $3000.00 is required a week prior to the scheduled court date.

Contacting Me:

Due to my work schedule I am not always readily available by telephone. Although I am usually in the office between the hours of 7:00 a.m. to 6:00 p.m. Mondays through Thursdays, I do not pick up the phone when I am with a client. When I am unavailable, you may leave me a message on the answering machine that I will monitor frequently. I will make every effort to call you within the day that you make the call or at least within 24 hours, with the exception of holidays and weekends. When you call, please leave me your name, a number where you can be reached, and the reason for your call. In the case of emergencies, please cell phone at (857) 544-5068. If you are unable to reach me and feel that you cannot wait for me to return your call, please call your family physician, 911, or go your nearest hospital emergency room. You may also contact the suicide and crisis center hotline at (214) 828-1000 or the Counseling and Crisis Line at (972) 233-2233. During times that I schedule my vacations, emergencies may be handled by hospital emergency rooms, psychiatric hospitals, or the clinician on call.

While I have an email address, this should not be used for emergencies as the messages will not be delivered in a timely manner and are not as confidential as you might expect the U.S. mail to be.

Limits on Confidentiality:

The law protects the privacy of all communications between a patient and a psychologist. In most situations I can only release information if you have signed an authorization or consent form. However there limits to confidentiality and under certain circumstances, authorization or consent is not needed. Mental Health Professional are mandated by law to notify appropriate authorities in the following situations: if I are believe you are a danger to yourself or others; if you are a minor, an elderly person, or disabled and I believe you are the victim of abuse or exploitation; or if I believe a child has been physically, sexually, or emotionally abused by you. Additionally, I am required by law if I learn that you have been abused by another mental health professional.

Confidential information may also be revealed if a court order has been issued in custody disputes or other legal proceedings; if disclosures are required by your insurance company; for collection of overdue fees; for health oversight activities, if a lawsuit has been filed against me; if a patient is filing a worker's compensation claim; or during consultation with other professionals (in this case the identification of the patient will not be revealed).

If couples are seen conjointly or members are seen in family therapy, I will not share information of each party without the written consent of all adult patients. Should you become involved in a divorce or disputed custody proceedings in the future, I will not testify in behalf of either spouse during these proceedings.

Professional Records:

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. The Clinical Record will have information about the reason you are seeking therapy, your medical and social history, your diagnosis, therapy goals, progress in treatment, and billing and insurance information. If you request it in writing, you may have a right to review or receive a copy of your Clinical Record. If you request access to your Clinical Record, I request that you initially review them in my presence because sometimes the information can be misinterpreted and/or may be upsetting. Otherwise I can send them to another mental health professional. The cost of copying your Clinical Record will be $ .35 per page. If I refuse your request for access to your Clinical Record, you have a right of review.

In addition to your Clinical Record, I will also have a set of Psychotherapy Notes which are kept in a separate area of your chart. These notes include the personal information you share with me, my impressions, and other information about you that was provided for me. These notes are intended for my own use to assist me in providing you with treatment. These psychotherapy notes cannot be sent to your insurance company or anybody else without your written, signed Authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that the release would be harmful to your physical, mental, or emotional health.

Patient Rights:

HIPAA provides you with several new and expanded rights with regard to your Clinical Record and disclosures of Protected Health Information. You may request that I may amend your record ; request restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which the protected health information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policy and procedures.

Minors & Parents:

Minors and parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is critical to successful progress, particularly with adolescents, it is my policy to request an agreement from the parents to consent to giving up their access to their child's records. If they agree, during treatment, I will provide them with general information about the child's progress, unless the child allows me to share specific information discussed in therapy. Information that will always be related to the parents will be any information that the child reveals to me that s/he intends to harm her/himself or someone else or that they are being abused or neglected in some way.

Billing and Payment:

You will be expected to pay for each session at the time of services unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installation plan. If your account is delinquent for more than 60 days and arrangements for payments have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which may require me to disclose otherwise confidential information. In most collection situations, the only information I may release would be the patient's name, the type of services provided, and the amount that has been unpaid. If legal action is necessary, then these costs will be included in the claim.

Insurance Reimbursement:

If you have a health insurance, it will usually provide some coverage for mental health treatment. While I can help you fill out some forms and help you receive the benefits to which you are entitled, it is you (not your insurance company) who is responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy will cover. You should carefully read the section in your insurance coverage booklet that describes your mental health services and talk your plan administrator if you have any questions.

If I file a claim for you, your signature below authorizes payment of benefits to be paid directly to Pushpa Chauhan, Psy.D. If your insurance company accidentally remits the payment to you, then you will agree to send the check along with the paperwork to me.

You should be aware that by getting services paid through your insurance company, your insurance company requires that I provide them with information relevant to the services I provided to you. I am required to provide them with a diagnosis and in some cases additional information such as treatment plans, treatment summaries, and/or copies of your entire Clinical Record. I will make every effort to provide only the minimum information in order to get the claim paid or to get coverage for additional sessions. The insurance company will probably store this information in their computer, and while they claim to keep the information confidential, I have no control of what they do once it is in their hands.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE AGREEMENT AND AGREE TO ITS TERMS. THE SIGNING OF THIS AGREEMENT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of patient, parent, or legal guardian Date

Lazaro Counseling Center, LLC
Authorization Form

Many insurance companies often want your therapist to communicate with your Primary Care Physician regarding your treatment. It is your right to agree to or refuse to this request. If you allow your therapist to release this information, it can be very helpful in coordinating your care.

Please sign and date only if you do not want information sent your PCP.

I decline to have any information sent to my Primary Care Physician

Signature:_____ Date:_____
Patient, Parent, or Legal Guardian

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize **Pushpa Chauhan, Psy.D.** to Release to/obtain from (circle one or both):

Name:_____

Address:_____
Street City State Zip Code

Phone:_(_____)_____ Fax:_(_____)_____

The information released will be limited to:_____
Social and/or psychological history, diagnostic impression, test results, reports, consult, etc.

I am requesting my psychologist to release this information for the following reasons:_____

_____
Treatment coordination, testing, psychological evaluation, etc.

This authorization will remain in effect until _____ or 6 months from the date that I terminate therapy.

You have a right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I further understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature:_____Date_____
Patient, Parent, or Legal Guardian

Lazaro Counseling Center, LLC
Overview Of Key Billing Policy

[ ]UNINSURED PATIENTS

Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid at the time of the service will be automatically charged to your designated card below.

[ ]INSURANCE ASSIGNMENT

- **Insurance Coverage:** We will communicate an estimate of insurance benefits at the onset of treatment. We strongly encourage you to contact your insurance company to verify your coverage. This estimate of benefits is not a guarantee of coverage, and you are ultimately responsible for any fees not paid by your insurance plan.
- **Copayments:** You may have a copayment, which is a fixed payment due at the time of service.
- **Coinsurance:** You may also have to pay co-insurance, which is a percentage of the session fee unpaid by your insurance company. This is also due at the time of service.
- **Deductibles:** You are responsible for full payment of fees until your deductible amount is met.
- **Billing:** We will bill your primary insurance policy for services rendered. We do not bill secondary insurance.
- **Unpaid Claims:** We will make every effort to secure payment from your insurance company. If your insurance company does not submit payment after **60 days**, you will be responsible for the payment of those fees and these will be charged to the credit card account on file. Any payments made on these claims thereafter will be immediately refunded to you.
- **Cancellations:** Insurance does not pay for missed appointments or cancellations.

Cancellation Policy for all clients: Since each appointment time is reserved exclusively for you or your child, you must give 24 business hours' notice to cancel or reschedule your appointment. Business hours do not include weekends or holidays, therefore, Monday appointments will require notification before 5:00 p.m. the preceding Friday or in case of an appointment after a holiday, notification before 5:00 p.m. the day prior to a holiday. Without this advanced notice, you are by law, responsible for the full payment of the session fees. The exception to cancellation charges include: a) you are able to reschedule your appointment within the week; b) your session falls on a holiday; c) your session is during a therapist's absence (e.g. illness, vacation); d) you or your child has a significant illness; or e) you have a significant scheduling conflict and provide the 24 business hours notice.

We require you to provide a credit card to have on file in order to process payments.

CREDIT CARD: □VISA □MC □DISCOVER

CARDHOLDERS NAME:_____

BILLING ADDRESS:_____

_____

CARD #:_____ EXP. DATE:_____THREE DIGIT CID NUMBER:_____

I agree to the above terms and authorize Lazaro Counseling Center, LLC. to charge the credit card on file for the policies outlined above.

_____ _____

SIGNATURE DATE

Lazaro Counseling Center, LLC
Diagnostic Information

What events or symptoms have caused you to seek counseling?_____

_____

When did these problems/symptoms first start?_____

How often do the symptoms occur?_____

Have you ever sought previous counseling or help for these problems, symptoms, or issues. If so when, where, and for how long? _____

Do you have any medical issues that may contribute to these symptoms?_____

_____

Please circle any of the following that trouble you:

Anxiety	Depression	Anger	Sexual Abuse
Withdrawal/isolation	Disruptive Behavior	Low self esteem	Difficulty sleeping
Guilt	Drug/Alcohol use	Inattentive	Conduct/legal problems
Loneliness	Jealousy	Argumentative	Suicidal feelings/actions
Impulsivity	Easily overwhelmed	Feeling tired	Loss of interest in activities
Blaming others	Procrastination	Loss of interest in sex	Weight issues/loss/gain/loss of appetite
Unhappy	Agitated	Frequent mood changes	Destruction of objects or property
Hygiene problems	Hopelessness	Feeling inadequate	Feelings of fear or panic
Racing thoughts	Disturbing thoughts	Authority problems	Nightmares/night terrors/sleepwalking
Physical abuse	Avoiding crowds	Feeling unappreciated	Difficulty making decisions
Excessive worrying	Tardiness/Absenteeism	Reckless spending	Preoccupation with sex
Irritability	Excessive shyness	Embarrassment	Repetitious behaviors/thoughts
Distractible	Poor concentration	Difficulty breathing	Excessive sweating
Easily startled	Forgetfulness	Social immaturity	Lack of motivation
School problems	Violence	Aggressiveness	Family conflict
Selfishness	Poor judgment	Impatient	Cutting/burning/hurting self
Excessive crying	Social problems	Not following rules	Communication difficulties
Feeling rejected	Perfectionism	Feeling tense	Feelings easily hurt