

**PATIENT INFORMATION**

Date \_\_\_\_\_  
Patient \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Patient SS# \_\_\_\_\_

**CONTACT NUMBERS**

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_  
Phone \_\_\_\_\_

**CONSENT TO TREAT (MINOR)**

As parent or guardian of the above named patient, I authorize Jeffrey K Fletcher, M.A. to provide mental health treatment for the patient.

X \_\_\_\_\_  
Parent or Guardian Signature Date

**PAYMENT**

The fee for an hour session is \$100.00  
The fee for 1.5 hour group therapy is 35.00  
Court Testimony fee is 250.00 per hour / portal to portal with a deposit of four hours due prior to the court date.

**CONFIDENTIALITY**

By initialing the following I agree to and fully understand the following limitations to confidentiality...

- \_\_\_\_\_ Suspected abuse of a child or the elderly
- \_\_\_\_\_ In case of imminent danger to the life of the client or others
- \_\_\_\_\_ In response to a judge order

**HIPAA NOTICE**

\_\_\_\_\_ I have received, read, and understand the HIPAA notice provided

**COUNSELING AGREEMENT**

\_\_\_\_\_ I agree to pay the full session fee if I do not attend my scheduled appointment and fail to notify no later than **24 hours** prior to the appointment time. Insurance will not compensate a no-show session. I also understand usual session charges will be applicable to telephone consultations at 15 minute intervals. **This policy is strictly enforced.**

\_\_\_\_\_ Office hours are 8am – 6pm Monday – Thursday. Phone calls, emails, and text messages will replied to within 24 hours during regular business hours and within the next business day if received on the weekend. Please be informed, phone calls, emails, or text messages will not be responded to after hours, on the weekend, or government recognized holidays. If you have an emergency please call 911 or go to your local emergency room.

\_\_\_\_\_ All requests for records will be charged 25 dollars for the first 20 pages and the .25 per each page over 20 pages.

**NOTICE CONCERNING COMPLAINTS**

Assistance in filing complaints about any therapist is available by calling the Texas State Board of Licensed Professional Counselors at 1.800.942.5540

**Patient Signature**

X \_\_\_\_\_  
Responsible Party Signature Date

**Jeffrey K. Fletcher, M.A.**  
**-LICENSED PROFESSIONAL**  
**COUNSELOR SUPERVISOR**  
**-LSOTP-S**