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

HIPPA 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.

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