Individual Client Information Questionnaire

Date:___________________

Thank you for your cooperation in completing this questionnaire. It will be helpful in planning therapeutic services for you**.**

Please answer each item carefully and completely, and use the back of the paper if adequate space is not provided for you to answer any questions.

If the client is a minor, please complete the intake packet on behalf of the child.

CLIENTS FULL NAME: ____ AGE: ________

(IF A MINOR) LEGAL GUARDIAN'S FULL NAME: ____

CLIENTS MAILING ADDRESS: ____

CITY: _____________________________ STATE: _________ ZIP: _______________

PRIMARY PHONE NUMBER TO CONTACT: _________________________ OTHER PHONE: __________________

EMAIL ADDRESS: ____

If necessary, may we leave a voice or text message at your primary phone number and/or correspond with you via email?
❑ Yes ❑No
If you answered No, please tell us the preferred way in which you would like us to communicate with you:
____

RESPONSIBLE PERSON'S ADDRESS IF DIFFERENT FROM ABOVE:

____ CITY: ________________ STATE: _______ ZIP: __________

CLIENTS SOCIAL SECURITY NUMBER: _______-______-_________ DOB: _____/______/_________

CLIENT'S OCCUPATION: _____________________________EMPLOYER: _______________________________

CLIENT'S MILITARY SERVICE: ____

IF STUDENT, SCHOOL: ____

HIGHEST LEVEL OF EDUCATION COMPLETED: ❑HS ❑GED ❑CERTIFICATE ❑BACHELOR ❑MASTERS

❑DOCTORATE ❑OTHER _______________________ AREA OF STUDY _________________________________

EMERGENCY CONTACT: Name: _______________________________________ Phone: _____________________

Relationship: __________________________________

Name of Spouse or Partner: ______________________________ Length of Relationship: ____________

Partners Email Address: ______________________________ Phone: ____________________

❑Single ❑Married ❑Non-Legal Separation ❑Legally Separated❑Divorced ❑Widowed ❑Committed Relationship

❑Currently in a Blended Family with your Spouse or Partner

❑Never Married If you are married, please select one of the following: ❑1st❑2nd❑3rd❑4th❑5th Marriage
If you are divorced, how many times have you experienced divorce? ❑Once ❑More Than Once

❑Male ❑Female❑Transgender

PREGANCIES (this is for both female, male, and transgender persons to complete related to the number of children you have):

1st ❑carried full term and successful delivery ❑abortion ❑miscarriage ❑still birth ❑natural birth ❑c-section
❑child being raised by me ❑raised child to adulthood ❑child was placed in adopted
Current age of child ________ Name of Child __________________________ ❑Male ❑Female
❑child was not adopted but raised by someone other than myself

2nd ❑carried full term and successful delivery ❑abortion ❑miscarriage ❑still birth ❑natural birth ❑c-section
❑child being raised by me ❑raised child to adulthood ❑child was placed in adopted
❑child was not adopted but raised by someone other than myself
Current age of child ________ Name of Child __________________________ ❑Male ❑Female

3rd ❑carried full term and successful delivery ❑abortion ❑miscarriage ❑still birth ❑natural birth ❑c-section
❑child being raised by me ❑raised child to adulthood ❑child was placed in adopted
❑child was not adopted but raised by someone other than myself
Current age of child ________ Name of Child __________________________ ❑Male ❑Female

4th ❑carried full term and successful delivery ❑abortion ❑miscarriage ❑still birth ❑natural birth ❑c-section
❑child being raised by me ❑raised child to adulthood ❑child was placed in adopted
❑child was not adopted but raised by someone other than myself
Current age of child ________ Name of Child __________________________ ❑Male ❑Female

FAMILY OF ORIGIN: ❑raised by birth parents ❑raised by single parent ❑raised by person(s) other than parents
❑raised by shared custody of divorced parents ❑adopted
Birth mother: ❑Living ❑Deceased ❑Unknown / Birth father: ❑Living ❑Deceased ❑Unknown

Please describe your father: ____

Please describe your mother: ____

How would you describe yourself within the context of your family:

____

Is your family a good support system to you today? ______________________________

Please list yourself and your siblings in birth order oldest to youngest and include step-siblings and also Male or Female and Biological, Step, or Adopted:

Self, Sister or Brother	M / F	B / S / A	Describe them in your own words:
______________________	______	________	____
______________________	______	________	____
______________________	______	________	____
______________________	______	________	____

SPIRITUAL AFFILIATION / FAITH / BELIEF: ____

If your childhood faith is different from your current faith, please list your childhood faith: __________________

What ways do you embrace and/or practice your Spiritual Beliefs? ______________________________________

____

Please share anything you believe is important for your therapist to know about your Spiritual beliefs and/or

practices: ____

____

CULTURAL PRACTICES: Please share anything you believe is important for your therapist to know about your Culture(s)

and/or cultural beliefs and practices: ____

____

How where you referred to H3 Counseling, LLC or Dr. Crystal Hollenbeck? ❑Internet ❑TV ❑Friend ❑Family Member

❑Co-Worker ❑Therapist ❑Physician ❑Psychiatrist ❑Church ❑Attorney ❑Student ❑Other______________________

We would like to thank the individual who referred you to us. Please provide the person's name **only** if you are giving us permission to contact them:

Referral Name: ____

Referral Contact Information if Known: ____

DATE OF LAST PHYSICIAN VISIT: ______________________

Purpose for Visit: ____

DATE OF LAST GYNOCOLOGIST VISIT:__________________

Purpose for Visit: ____

DATE OF LAST DENTAL VISIT: ________________________

Purpose for Visit: ____

DATE OF LAST PSYCHIATRIST VISIT: ___________________

Purpose for Visit: ____

LIST ANY HEALTH PROBLEMS THAT YOU ARE CURRENTLY RECEIVING TREATMENT FOR:

PROBLEM	TREATMENT PROVIDER

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING NON-PRESCRIPTION:

MEDICATION	DOSAGE	FREQUENCY	DURATION	REASON

LIST ANY SURGERIES OR BROKEN BONES YOU HAVE HAD SINCE BIRTH:

SURGERY / BROKEN BONES	DATE
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

PRESENTING PROBLEM:

PLEASE STATE IN YOUR OWN WORDS THE NATURE OF THE ISSUE(S) THAT LED YOU TO SEEK COUNSELING:

____

____

____

____

____

____

WHEN DID YOUR ISSUE(S) BEGIN? GIVE DATES AS BEST AS YOU CAN REMEMBER:

____

____

____

____

LIST ANY COUNSELING, PSYCHOLOGICAL, AND/OR PSYCHIATRIC TREATMENT RECEVED:

TYPE OF TREATMENT PROVIDER DURATION DIAGNOSIS RECEIVED

________________ ________________ ________ ________________

Date(s) of Treatment ____________________ ❑Inpatient ❑Outpatient ❑Voluntary ❑Involuntary

❑ BENEFICIAL ❑NOT BENEFICIAL Additional Comments: ______________________________

____

TYPE OF TREATMENT PROVIDER DURATION DIAGNOSIS RECEIVED

________________ ________________ ________ ________________

Date(s) of Treatment ____________________ ❑Inpatient ❑Outpatient ❑Voluntary ❑Involuntary

❑ BENEFICIAL ❑NOT BENEFICIAL Additional Comments: ______________________________

____

TYPE OF TREATMENT PROVIDER DURATION DIAGNOSIS RECEIVED

________________ ________________ ________ ________________

Date(s) of Treatment ____________________ ❑Inpatient ❑Outpatient ❑Voluntary ❑Involuntary

❑ BENEFICIAL ❑NOT BENEFICIAL Additional Comments: ______________________________

____

PLEASE LIST ANY CURRENT OR PAST USE OF THE FOLLOWING AND IF YOU HAVE SOUGHT TREATMENT.

	PAST/CURRENT	FREQUENCY	TREATMENT – RECOVERY
ALCOHOL			
CIGARETTES			
TOBACCO			
MARIJUANA			
ILLEGAL SUBSTANCES			
PRESCRIPTION DRUGS			

Have you ever been treated for an eating disorder? ❑Yes ❑No ❑Inpatient ❑Outpatient

Treatment Provider: ________________________________ Date: ________________

Treatment Provider: ________________________________ Date: ________________

Have you ever been treated for sexual addiction? ❑Yes ❑No ❑Inpatient ❑Outpatient

Treatment Provider: ________________________________ Date: ________________

Treatment Provider: ________________________________ Date: ________________

Have you ever been treated for issues related to physical, emotional, mental, or sexual abuse?

❑Yes ❑No ❑Inpatient ❑Outpatient

Treatment Provider: ________________________________ Date: ________________

Treatment Provider: ________________________________ Date: ________________

Have you ever been convicted in a court of law for committing a crime? ❑Yes ❑No

Charge ________________________________ Date: ________________

Charge ________________________________ Date: ________________

Please circle any of the following that you are CURRENTLY experiencing.

Nervousness	Shyness	Suicidal Thoughts	Homicidal Thoughts	Anxiety
Depression	Anger	Separation	Drug Use	Relaxation
Legal Matters	Education	Bowel Troubles	Sexual Dysfunction	Sex Addiction
Self-Control	Memory	Career Choices	Parenting	In-Laws
Finances	Work	Social Activity	Marriage	Pain
Sleep Disturbance	Concentration	Self-Esteem	Spiritual Issues	Temper
Insomnia	Nightmares	Fatigue	Irritability	Health Problems
Phobia	Obsessions	Children	Alcohol Use	Abuse
Headaches	Stress	Weight	Friends	Sadness
Loneliness	Inferiority	Fears	Ambition	Divorce
Smoking	Yelling	Isolation	Relationships	Health Problems
Emotional	Drama	Hyperactive	Workaholic	Controlling
Self-Harm	Indecision	Demanding	Panic	Negativity

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress):*

____
1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: □ Yes □ No. Have You Experienced Them in the Past: □ Yes □ No

Have You Ever Attempted Suicide: □ Yes □ No. If Yes, When and How: ____

____

____

____

____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: ____

____

____

____

Please provide any additional information you may find beneficial for the therapist to know about you.

____

____

____

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PLEASE READ AND SIGN THE FOLLOWING COUNSELING INFORMED CONSENT
IF THE CLIENT IS UNDER 18 YEARS OF AGE – THIS AGREEMENT MUST BE SIGNED BY THEIR PARENT OR GUARDIAN

"I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship upon due notice to my therapist."

Please Initial Here: _________________

I understand that ALL fees, as outlined on a separate attached and signed sheet, are due at the time services are rendered unless previous arrangements have been made. I UNDERSTAND THAT FAILURE TO CANCEL A SCHEDULED APPOINTMENT 48 HOURS IN ADVANCE, FOR ANY REASON, WILL RESULT IN ME BEING CHARGED THE FULL AMOUNT FOR THAT SESSION.

Please Initial Here: _________________

I understand that in order for Crystal Hollenbeck, EdD, LMHC to provide the best treatment possible, she has my permission to consult with other professional therapists, educators, and/or supervisors about my treatment and care as long as no identifying information is used in consultation. Information concerning my treatment cannot be divulged to other parties without my prior written consent unless directed by Florida Law (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others, and specific information subpoenaed by a court of law.).

Please Initial Here: _________________

I understand counseling services are provided by Crystal Hollenbeck, EdD, LMHC. I understand that she earned a Doctorate of Education Degree in the field of Counselor Education & Supervision from an accredited graduate program, and has been licensed by the state of Florida as a Mental Health Counselor (License #MH11615). I also understand that Crystal Hollenbeck holds certifications in Sex Therapy, Sex Addiction Therapy, EMDR Therapy and Anger Management.

Please Initial Here: _________________

Although I expect benefits from this therapeutic treatment and counseling services, such benefits or particular outcomes cannot be guaranteed. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing. I understand that Crystal Hollenbeck and H3 Counseling, LLC are not providing an emergency service or on-call service of any kind. Therefore, at anytime I become extremely emotionally distressed or are in danger of hurting myself or someone else, I am responsible to call 911 for assistance.

Please Initial Here: _________________

I understand that regular attendance will produce maximum results, but I am free to discontinue treatment at any time. I understand that a final closure/summary session is highly recommended to get the greatest benefits.

Please Initial Here: _________________

I understand that my counseling records and conversations with Crystal Hollenbeck, EdD, LMHC, are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others, and specific information subpoenaed by a court of law.) I understand that confidentiality cannot be guaranteed if I choose to participate in counseling sessions or communication with Crystal Hollenbeck, EdD, LMHC via email, text, phone, or *VSee,* or any other means other than with her alone in her office.

Please Initial Here: _________________

Therefore, I will not hold H3 Counseling, LLC or Crystal Hollenbeck, EdD, LMHC, responsible for any confidentiality issues related to communication or counseling sessions conducted outside the physical office.

Please Initial Here: _________________

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily. My signature below indicates that I grant informed consent for Crystal Hollenbeck, EdD, LMHC, to provide counseling services to myself and or minor members of my family.

Please Initial Here: _________________

Printed Client Name: ____ **Date:** ______________________

Client Signature: ____ **Date:** ______________________

Parent or Guardian Signature: ____ **Date:** ___________________

PLEASE READ AND SIGN THE FOLLOWING COMMUNICATION POLICY:

Communication and Confidentiality: H3 Counseling recognizes that the majority of our communication in today's society is conducted through the use of cell phones, computers, laptops, ipads, text messages, social media, and email accounts. In an effort to make communication convenient, Crystal Hollenbeck, Ed.D, LMHC will be glad to communicate with you through any of these options at your own risk and with certain limitations, in an effort to accommodate you and make reasonable attempts to protect your confidentiality. You will be given Dr. Hollenbeck's direct cell phone number and are free to communicate via text messages, phone calls, and/or email. However, please be aware that confidentiality can't be protected with the same level of privacy as communicating with her in her office face-to-face. Dr. Hollenbeck protects client communications on all electronic devices with two passwords and physical files behind a double locked door and locked file cabinet in her physical office. Therefore, by signing this policy, you understand and are in agreement that Crystal Hollenbeck, EdD, LMHC and H3 Counseling, LLC are not and will not be held responsible for the confidentiality and privacy of any communication conducted outside of the physical counseling office and those limitations specified by HIPPA (you will read and sign the HIPPA Notice of Privacy Practices as part of your initial paperwork). In addition, you acknowledge and understand that Dr. Hollenbeck has no obligation to engage in any communication outside of her physical office in face-to-face sessions, but will strive to address all of your communication in a timely fashion when possible.

Please Initial Here: _________________

In Case of an Emergency: Clients agree to call 911 in the case of an immediate emergency and not to rely on contacting Dr. Crystal Hollenbeck when in crisis outside of the office setting. Dr. Hollenbeck will attempt to accommodate any client who wants to schedule a same day appointment due to a sudden crisis, but can't guarantee that a time will be available.

Please Initial Here: _________________

Social Media: Crystal Hollenbeck, EdD, LMHC has a professional *Facebook* page that you, the client, are welcome to "like" and post relevant comments on freely. This professional page has mental health and relationship information that may be helpful to you and also lists any information about H3 Counseling, LLC updates. In addition, Dr. Hollenbeck has a professional *Twitter* account you may follow @Crystal_MH, that also contains the same information listed on *Facebook.* In an effort to protect the client's privacy, Dr. Hollenbeck and H3 Counseling will not knowingly request or accept any friend requests on personal *Facebook* pages, *LinkedIn* profile pages, or *Twitter* accounts.

Please Initial Here: _________________

Distance Counseling Sessions: Crystal Hollenbeck, EdD, LMHC is a certified Distance Credentialed Counselor (DCC) by the Center for Credentialing and Education, Inc. and offers counseling sessions via the video program *VSee* (www.VSee.com) utilizing a computer and/or phone, and via the *iphone* program *facetime*. Video sessions may be conducted only after an in-office initial assessment is conducted face-to-face with Dr. Hollenbeck. Distance counseling may be beneficial to the client as a way to continue the therapeutic process when traveling for business and/or personal reasons and/or after moving to a new location while seeking a new therapist, and on occasions when the client is confined to the home, as these situations may normally cause interruption in the therapeutic process without the option for Distance Counseling. Although Dr. Hollenbeck may communicate with you for your convenience via email, text, and phone calls, she does not provide counseling services via email or text messages, or with any person she has not met in person for at least one session in her office (During the in-office session, she will answer any questions you may have related to distance counseling prior to utilizing the method). *VSee* is a HIPPA compliant program, *facetime* does not meet HIPPA requirements. Therefore, as a client, you understand that there is a risk of broken confidentiality associated with phone sessions other than *VSee*. You, the client, understand that you are responsible for your physical safety and privacy at the location you are physically present when engaging in Distance Counseling via phone and/or *VSee* sessions.

Please Initial Here: _________________

I have read, understand, and agree with the above Communication Policy.

Printed Client Name: ____

Client Signature: ____ **Date:** ______________________

Parent or Guardian Signature: ____ **Date:** ______________________

PLEASE READ AND SIGN THE FOLLOWING LEGAL INVOLVEMENT POLICY

If your visit to my office will require my involvement in a legal process, i.e. deposition, court ordered evaluation, court appearance, or the like, I cannot guarantee confidentiality. Although I will follow all statutory obligations to honor your privacy and your confidentiality, the court can order my disclosure under specific circumstances beyond my control. Please consult with your attorney prior to your first session if you believe my services will involve the legal system.

ALSO, please be aware that my fees for involvement in the legal process are $350.00 per hour, with a one (1) hour minimum. The legal process is time intensive and often requires me to cancel or reschedule appointments with other clients. In order to recoup expenses for legal processes, I must charge these additional fees. Your account must be current prior to my involvement.

If the client is a minor the individual signed below will be responsible for the fees incurred as a result of legal proceedings. If the individual signing is not the minor's parent(s) or legal guardian, I must have legal documentation or responsibility on file prior to my first session with the child.

The fees for my involvement in the legal process are neither billable nor reimbursed by your insurance carrier. All fees are your responsibility and are payable in advance. I will not balance bill third parties or attorneys. I will accept cash, check, or credit card for our fees. I must have a valid credit card number on file. A form for this purpose is attached at the end of this intake package for your convenience.

I am not an attorney. For information of a legal nature, please consult and follow the advice of a competent attorney. If your attorney requests information regarding your sessions with me, you will need to execute a signed written waiver of confidentiality. Fees for reports, consultations, or recommendations are your responsibility and are billed at the $350.00 per hour rate. A total breakdown of my Legal Billing Fees can be further explained if applicable to you. As in all legal proceedings, final disposition is the responsibility of the court.

I have read the above Legal Involvement and agree to its terms.

Printed Client Name:____

Printed Name of Responsible Party if Other than Client: ____________________________________

Signature of Responsible Party: _________________________________ **Date:** ______________

Current Fee Structure for H3 Counseling, LLC

As of February 1, 2016

THIS FORM MUST BE SIGNED PRIOR TO THE FIRST SESSION. BY SIGNING THIS AGREEMENT, I ACCEPT RESPONSIBILITY TO PAY THESE FEES AS SERVICES ARE RENDERED. I FURTHER RECOGNIZE AND AGREE THAT SHOULD COLLECTION PROCEEDINGS BE NECESSARY UPON MY DEFAULT, I WILL BE RESPONSIBLE FOR ANY LEGAL FEES INCURRED AS A RESULT OF SUCH PROCEEDINGS. IF SPECIAL ARRANGEMENTS FOR PAYING FOR MY SERVICES OR CHANGES IN RATES ARE AGREED UPON, THEY WILL BE INCLUDED WITH THIS SIGNED AGREEMENT AND WILL BECOME PART OF THE COUNSELING RELATIONSHIP. IF I HAVE MADE ARRANGEMENTS FOR SOME OTHER THIRD PARTY TO PAY FOR SERVICES, I AGREE TO HAVE THEM SIGN THIS AGREEMENT PRIOR TO THE FIRST SESSION.

Initial Intake Interview Session …………….$240.00 ~ 80 Minutes
Individual, Couple, or Family Session ……..$160.00 ~ 45 Minutes | $240 ~ 80 Minutes | $320 ~ 110 Minutes
Three-Day Intensive Therapy ……………...$4,800.00 ($2,400.00 Non-Refundable Deposit Required to Schedule)

I UNDERSTAND THAT FAILURE TO CANCEL A SCHEDULED APPOINTMENT 48 HOURS IN ADVANCE WILL RESULT IN ME BEING CHARGED THE FULL AMOUNT FOR THAT SESSION.

I UNDERSTAND THAT ADDITIONAL PAPERWORK AND A NON-REFUNDABLE DEPOSIT IN THE AMOUNT OF $2,400.00 IS REQUIRED TO SCHEDULE A THREE-DAY INTENSIVE THERAPY WITH DR. CRYSTAL HOLLENBECK. I UNDERSTAND THAT THE BALANCE DUE AMOUNT OF $2,400.00 IS REQUIRED 7 DAYS PRIOR TO THE SCHEDULED DATE OF THE INTENSIVE.

Please Initial Here: ________________

Involvement in a Legal Matter and/or Process Fee is $350.00 per 60 Minutes with a Minimum Charge of $350.00. Legal Involvement Fee Includes services such as depositions, appearances, letters, assessments, evaluations, and all communication via phone, text, email, in office visits, fax, etc.

All Assessment Materials, Workbooks, and Reading Material in any form used for diagnostic and therapeutic services will require a fee. These fees will vary depending on the specific material being utilized and the time required for scoring and interpretation by the therapist. All fees will be discussed with the Client on an individual basis as rendered necessary for proper diagnosis and treatment.

If you believe your insurance may reimburse you for your visits, please request an additional receipt from me that will include the proper information you will need to provide to your insurance carrier. I do not, in any circumstance, file insurance paperwork or are responsible for any reimbursement issues between you and your insurance carrier.

Please Note: In the event that your insurance company fails to reimburse for counseling services for any reason, or determines that agreed upon fees are the patient's responsibility - you will be responsible for the full payment.

"I have read the above fee schedule and agree to its terms and conditions. I also have the right to a copy of this agreement upon request."

Printed Client Name: ____

Printed Name of Responsible Party if Other than Client: ______________________________________

Signature of Person Responsible for Payment ________________________________ Date: ________________

Driver's License Number and State ____

Responsible Party's Social Security Number ____

PLEASE READ AND SIGN the Financial Policy for H3 Counseling, LLC

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy, which I require you to read and sign prior to any treatment. All clients must complete this Intake form before the first session.

FULL PAYMENT IS DUE AT TIME OF SERVICE

Acceptable Forms of Payment: CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS, AND DISCOVER

Please make checks payable to **Crystal Hollenbeck** There will be a $50.00 fee for checks that are returned as non-sufficient funds or non-payable. If your preferred payment is via check, you agree to provide a credit card that will be kept on file and will be charged for the amount of a check that is returned plus the $50.00 fee.

Regarding Indemnity Insurance: Your insurance policy is a contract between you and your insurance company. All insurance contracts are different depending on employer benefits, deductible amounts, co-pays, and etc. In order to keep my fees as low as possible, it is not possible for me to hire an insurance manager to determine what benefits your insurance may pay toward your treatment. What I can offer you is a "Super Bill" Receipt of your total payment with a diagnostic code located on it after I have determined one, for you to submit to your Insurance Company for their reimbursement to you. Please inform me immediately if this option is what you would like to do so that I can note it on your account. I will not communicate with your insurance company for you. It is your total responsibility to seek reimbursement from your insurance carrier.

Usual and Customary Rates: This practice is committed to providing the best mental health treatment for my clients and I charge what is usual and customary for the area. You are responsible for payment regardless of any arbitrary determination of usual and customary rates imposed by your insurance company.

Minor Clients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit card or payment by cash or check has been received by the time service is rendered.

Third Party Payors: Any arrangements to have your bill paid by someone other than the responsible person signed below must be approved in writing prior to any services being provided.

Missed Appointments/Financial Responsibility: Session Cancellations must be done 48 hours in advance of the scheduled appointment time or you will be charged for the total amount of the scheduled session. If there is no cancellation and you do not show up for your appointment, our policy is to charge for the total amount of the scheduled session. When rescheduling an appointment, if you do not reschedule the appointment within the same week, our policy is to charge for the total amount of the session being cancelled. Please help me serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Printed Name of Client: ____ Date: ____________________

Printed Name of Responsible Party if Other than Client: ____

Signature of Client or Responsible Party: ____

Mandatory Credit Authorization for H3 Counseling, LLC

Dear Client,

By signing this form, you agree that any balance due will be charged to your credit card. If you have requested I provide you with the proper documentation for submission to your insurance company, I shall do so.

The Agreed maximum amount to be charged to your credit card for the counseling service provided today aligns with the previously outlined H3 Counseling, LLC Fee Structure in which you agreed to by acknowledgement with your signature.

Please note, your credit card information will be kept confidential and secure. Charges will appear on your credit card statement under the name H3 Counseling, LLC and you will be sent a receipt for services at the time of every payment via the email address you provide. Please provide an email address that is confidential for receipts to be sent.

By signing this form, I certify that this is my credit card and that I am legally authorized to give permission for its use. My signature further authorizes Crystal Hollenbeck and H3 Counseling, LLC to charge my credit card an amount not to exceed the agreed upon amounts listed in the H3 Counseling, LLC Fee Structure provided to me in writing. I understand that I may incur additional charges if my card is declined. I will notify H3 Counseling, LLC and/or Crystal Hollenbeck of any changes to my account.

This authorization will remain in effect for the duration of my treatment and I give permission for all charges including any standard fee increases or decreases verbally communicated to me by my therapist over the course of treatment.

This authorization may be cancelled through written notice to H3 Counseling, LLC.

Cardholder's Signature: ____ **Date:** ____________________

Client's Printed Name: ____ Date: ____________________

Cardholder Printed Name if Other than Client: ____

Cardholder Billing Address: ____

City______________________ State _________ Billing Zip Code __________________

❑Visa ❑Master Card ❑Discover Card ❑American Express

Number: ____

Exp. Date: ______/_______ Code: __________

Email Address to send receipt: ____

PLEASE COMPLETE THIS PAGE ONLY IN CASES WHERE
A MINOR CHILD
DOES NOT LIVE WITH BOTH LEGAL/BIOLOGICAL PARENTS

Parent's Information:

PRIMARY RESIDENCE OF THE MINOR CHILD:

Mother or Father's Name: ____ Married / Single / Divorced / Widowed

Phone: ___________________________ Email: ____

Address: ______________________________________ City: __________________ State: _______ Zip:___________

SECONDARY RESIDENCE OF THE MINOR CHILD:

Mother or Father's Name: ____ Married / Single / Divorced / Widowed

Phone: ___________________________ Email: ____

Address: ______________________________________ City: __________________ State: _______ Zip:___________

Document type that determined living arrangements of minor child (e.g. divorce, decree):

____

Describe the arrangement for seeking medical services on behalf of the minor child:

____

Please be aware that this office will be contacting the other parent via US Mail if both parties are not present during the initial intake session or have not made verbal contact with Crystal Hollenbeck.

Documentation may be requested to assure accurate arrangements for minor child