



## Individual Client Information Questionnaire

Thank you for your cooperation in completing this questionnaire. It will be helpful in planning therapeutic services for you. Please do not write on the back of the paper. Please use a blank sheet of paper if more space is needed. PLEASE ANSWER ALL QUESTIONS COMPLETELY AND PRINT CLEARLY. Thank you.

Date: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

If necessary, may we leave a voice or text message at 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:

\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MILITARY SERVICE: \_\_\_\_\_

IF YOU ARE A CURRENT STUDENT, NAME OF SCHOOL: \_\_\_\_\_

HIGHEST LEVEL OF EDUCATION COMPLETED:

HS  GED  CERTIFICATE  BACHELOR  MASTERS  DOCTORATE  OTHER \_\_\_\_\_

AREA OF STUDY \_\_\_\_\_

EMERGENCY CONTACT: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

NAME OF PARTNER OR SPOUSE: \_\_\_\_\_ Length of Relationship: \_\_\_\_\_

Partner's Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Single  Committed Relationship  Never Married  Married  Non-Legal Separation  Divorced  Widowed

Currently in a Blended Family with your Spouse or Partner

If you are married, please select one of the following:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>  5<sup>th</sup> Marriage

If you are divorced, how many times have you experienced divorce?  Once  More Than Once



**CHILDREN:** Please list the first name and age of your children from oldest to youngest.  
 Please list if they are Male or Female, Biological, Step, or Adopted, Living or Deceased, and Miscarriage or Abortion.  
 Please also list if they are living or deceased and if the child is deceased, please share the age and manner of death.

Name of Child	Age	M/F	B/S/A	L/D	M/A	(please share information about each child you think is important)
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Other than you, your partner, and/or your children, please list anyone else lives with you.

Name	M / F	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FAMILY OF ORIGIN:**

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:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



**REFERRAL INFORMATION:** 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: \_\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL HEALTH:**

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 ISSUES THAT YOU ARE CURRENTLY RECEIVING TREATMENT FOR:**

HEALTH ISSUE	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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



**LIST ANY COUNSELING, PSYCHOLOGICAL, AND/OR PSYCHIATRIC TREATMENT RECEIVED:**

<b>TYPE OF TREATMENT</b>	<b>PROVIDER</b>	<b>DURATION</b>	<b>DIAGNOSIS RECEIVED</b>
_____	_____	_____	_____

Date(s) of Treatment \_\_\_\_\_  Inpatient  Outpatient  Voluntary  Involuntary

BENEFICIAL  NOT BENEFICIAL Additional Comments: \_\_\_\_\_

<b>TYPE OF TREATMENT</b>	<b>PROVIDER</b>	<b>DURATION</b>	<b>DIAGNOSIS RECEIVED</b>
_____	_____	_____	_____

Date(s) of Treatment \_\_\_\_\_  Inpatient  Outpatient  Voluntary  Involuntary

BENEFICIAL  NOT BENEFICIAL Additional Comments: \_\_\_\_\_

<b>TYPE OF TREATMENT</b>	<b>PROVIDER</b>	<b>DURATION</b>	<b>DIAGNOSIS RECEIVED</b>
_____	_____	_____	_____

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 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 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 READ AND SIGN THE FOLLOWING COUNSELING INFORMED CONSENT**

“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 in writing. 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. I understand that 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:** \_\_\_\_\_

**Client 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 Crystal 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. Crystal 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 Crystal 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 Crystal Hollenbeck when in crisis outside of the office setting. Crystal 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, Crystal 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, Crystal 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 Crystal 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 Crystal 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:** \_\_\_\_\_



**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, understand, and agree with the above Legal Involvement Policy.**

**Printed Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **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 ~ 50 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 the 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.

**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. 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 which you agreed to by acknowledgement with your signature. In addition, the fees charged align with any fee increases since your original signature date.

Your credit card information will be kept confidential and secure. Square is the method used for credit card payment collection. Charges will appear on your credit card statement under the name H3 Counseling, LLC and you will be sent a receipt for services from Square 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. If you request a separate receipt to submit to your insurance company, it will be sent to you as a separate receipt document with additional diagnostic information.

\*\*\*\*\*

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: \_\_\_\_\_

Form containing fields for Client's Printed Name, Date, Cardholder Printed Name, Billing Address, City, State, Billing Zip Code, Payment Method (Visa, MasterCard, Discover Card, American Express), Card Number, Exp. Date, Code, and Email Address to send receipt.