Dr. Crystal Hollenbeck
H3 Counseling | Hope ~ Healing ~ Harmony

Individual Client Information Questionnaire
Therapy Consent, Policies, and Agreements

Thank you for your cooperation in completing this questionnaire. It will be helpful in planning therapeutic services for you.
PLEASE ANWER ALL QUESTIONS COMPLETELY AND PRINT CLEARLY. Thank you.

Date: _____

FULL NAME: _____ AGE: _____

GENDER: ❑ Male ❑ Female ❑ Other _____

EMAIL: _____PHONE: _____

If necessary, may I leave a voice or text message at the phone number and/or correspond with you via the email you provided?

❑ Yes ❑No If you answered No, please tell me the preferred way in which you would like me to communicate with you:

_____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ DOB: _____/_____/_____

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: _____

Partner's Address if different from yours: _____

❑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: ❑1st ❑2nd ❑3rd ❑4th ❑5th 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? _____

Is there anything else you would like to share about the family you were born into? _____

_____

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: _____

_____

_____

MEDICAL | MENTAL HEALTH:

DATE OF LAST PHYSICIAN 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 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: ______________________________

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 problematic sexual behaviors? ❑Yes ❑No | ❑Inpatient ❑Outpatient

Treatment Provider: _____ Date: _____

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: _____

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: _____

Charge _____ Date: _____

Please circle any of the following that you are CURRENTLY experiencing and/or are stressful.

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: _____

_____

WHY ARE YOU SEEKING COUNSELING? (Please explain what you would like help with or the issue(s) you want help addressing)

_____

_____

_____

_____

_____

_____

WHEN do you believe the issues and/or concerns began?

_____

_____

Please list two or more goals you hope to accomplish in the therapeutic process.

(1) _____

(2) _____

(3) _____

(4) _____

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

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. I understand that regular attendance will most likely 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. I understand if I do not have a session scheduled within 60 days, therapy with Dr. Crystal Hollenbeck will be considered terminated until I contact her to reestablish therapy sessions.

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 Dr. Crystal Hollenbeck 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.). I understand that if I disclose, during the therapeutic process, that I am abusing or have abused a child or vulnerable adult that Dr. Crystal Hollenbeck is a state mandated reporter and she will make a report to the Department of Children and Family Services.

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 Dr. Hollenbeck holds certifications in Sex Therapy, Sex Addiction Therapy, Betrayal Trauma, Trauma Recovery, EMDR Therapy, and Anger Management. I understand her complete list of credentials including educational degrees and certifications are listed on her website with public access. www.CrystalHollenbeck.com.

Please Initial Here: _____

Although I expect benefits from therapeutic treatment and counseling services, such benefits or particular outcomes cannot be guaranteed. Due to the counseling or therapy process, I understand that I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing. I may have assignments to complete between sessions. I understand therapy is not a quick fix. It takes time and effort, therefore, may move slower than my expectations. During the therapy process, goals will be identified, progress will be reviewed, and the treatment plan may be modified as needed. I understand Dr. Hollenbeck will work with me collaboratively towards a desirable outcome; however, it is possible that the goals of therapy may not be reached.

Please Initial Here: _____

I understand that Dr. Crystal Hollenbeck dba H3 Counseling, LLC is not providing an emergency service or on-call service of any kind. 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. Therefore, at any time I become extremely emotionally distressed or are in danger of hurting myself or someone else, I am responsible to call 988 or 911 for assistance.

Please Initial Here: _____

I understand Dr. Crystal Hollenbeck dba H3 Counseling, LLC protects client communications on all electronic devices with passwords and all physical files behind a locked door and locked file cabinets in her physical office. Communication outside of in-person, in-office interaction can't be guaranteed to be confidential. I understand there is a confidentiality risk when I communicate via text or email. I understand Dr. Hollenbeck prefers I bring all personal counseling information, questions, thoughts, experiences, etc. into the therapy session verses sharing them by email or text message. She recommends keeping notes or journaling and then share the information in the next counseling session.

I understand I can send documents by certified mail to Dr. Crystal Hollenbeck, H3 Counseling, 8015 International Drive, Box 302, Orlando, Florida, 32819 ahead of the scheduled session time or schedule an in-office session for my initial visit. In addition, I acknowledge and understand that Dr. Hollenbeck has no obligation to engage in any communication outside of her physical office in face-to-face sessions or during virtual sessions but will strive to respond to all of my communication by whatever means I use in a timely fashion when possible. Therefore, I will not hold Dr. Crystal Hollenbeck dba H3 Counseling, LLC responsible for any confidentiality issues related to communication or counseling sessions conducted outside the physical office

Please Initial Here: _____

Dr. Crystal Hollenbeck has a professional **X** *@DrCrystalH* page that you, the client, are welcome to follow. This professional page has mental health and relationship information that may be helpful to you and also lists any information about Dr. Hollenbeck's speaking engagements and article updates. Dr. Hollenbeck does not intentionally communicate, follow, or interact with clients through social media with the exception of someone reaching out to schedule an appointment or in another general manner. Please understand that she may not respond to connection requests in an effort to protect your privacy.

Please Initial Here: _____

I understand that Dr. Crystal Hollenbeck does not and will not give permission to record any therapy sessions and/or conversations for any reason. I understand it is illegal to record therapy sessions or conversations with Dr. Hollenbeck at any time without her written permission. I understand this includes any Artificial Intelligence (AI) note taking or *Zoom* capability note taking tools during *Zoom* counseling sessions.

Please Initial Here: _____

I understand that at this time, Dr. Crystal Hollenbeck does not utilize AI tools including AI-powered transcription for note taking or treatment planning. All clinical notes and records are created solely by Dr. Hollenbeck. If she decides to utilize AI Tools in the future to assist or enhance the quality and efficiency of certain aspects of the therapeutic process, she will seek my consent in writing.

Please Initial Here: _____

I understand that my counseling records and conversations with Dr. Crystal Hollenbeck 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 Dr. Hollenbeck via email, text, phone, or video, or any other means other than with her in person in her office. I have read and understand the HIPPA *Notice of Privacy Practices* provided to me by Dr. Hollenbeck.

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 Dr. Crystal Hollenbeck to provide counseling services to myself and/or my family members.

Please Initial Here: _____

Printed Client Name: _____

Client Signature: _____ **Date:** _____

TELEMENTAL HEALTH INFORMED CONSENT

Dr. Crystal Hollenbeck is a Board-Certified Telemental Health Therapist (BC-TMH) by the Center for Credentialing and Education, Inc. and offers counseling sessions via the HIPPA compliant video program *Zoom* utilizing a computer and/or phone. Although Dr. 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. Therefore, as a client, you understand that there is a risk of broken confidentiality associated with phone sessions other than *Zoom*. As the client, I understand that I am responsible for my own physical safety and privacy at the location I am physically using when engaging in counseling sessions via phone and/or *Zoom* sessions.

Please Initial Here: _____

I hereby consent voluntarily to participate in telemental health with Dr. Crystal Hollenbeck, Licensed Mental Health Counselor, as part of my psychotherapy treatment process. I understand that telemental health is the use of telecommunications or videoconferencing technology to provide mental health services in compliance with the federal Health Insurance Portability and Accountability Act (HIPPA). I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telemental Health Counseling:

I understand that I am under no obligation to engage in telemental health counseling and that it is an option in addition to in person sessions in one of Dr. Crystal Hollenbeck's office locations.

I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. I understand it is illegal to record my therapy sessions without the written permission of Dr. Crystal Hollenbeck.

I understand that it is my sole responsibility to be in a private and safe setting for Telemental Health sessions, I understand that I am to be the only person in the room for the sessions and that no children of any age can be present for the session. I understand the exception to this is if I am in a couples or family session and it communicated and agreed upon that there will be multiple people attending the session.

I understand that it is my sole responsibility for any electronic devices and internet services I use for Telemental Health.

I understand that the privacy laws that protect confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required. I understand and agree with Dr. Crystal Hollenbeck's assessment and discernment in any recommendations she may provide regarding the use of telemental health she deems in the best interest of my wellbeing.

I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will call Dr. Hollenbeck at 407.408.6521 to discuss the issue since we may have to re-schedule or continue with the use of facetime.

I understand that Dr. Crystal Hollenbeck may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I understand it is my responsibility to inform Dr. Crystal Hollenbeck of my location if it is different than the one provided below.

TELEMENTAL HEALTH EMERGENCY PROTOCOLS: Dr. Crystal Hollenbeck will need to know my location in case of an emergency. I agree to inform her of the address where I am at the beginning of each session if it is different than the address provided below. She also needs a contact person who she may contact on my behalf in a mental health crises or life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is (unless otherwise disclosed at the beginning of the session):

_____

_____

My Emergency Contact person's name, address, and phone number is:

_____

_____

I have read and understand the information above and will ask Dr. Crystal Hollenbeck any additional questions I may have regarding the use of Telemental Health Counseling Sessions.

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 $260.00 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, documentation, depositions, court appearances, travel, etc., I must charge for additional time and services. 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 information as to the financially responsibility party 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 fees. I must have a valid credit card number on file. A form for this purpose is attached within this intake information and policy 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 $260.00 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 Dr. Crystal Hollenbeck dba H3 Counseling, LLC

As of June 4, 2026

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 IN WRITING, THEY WILL BE INCLUDED WITH THIS SIGNED AGREEMENT AND WILL BECOME PART OF THE COUNSELING AGREEMENT. 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	$520 ~ 110 minute Session
Sessions following Initial Intake	$260 ~ 50 Minutes | $390 ~ 80 Minutes | $520 110 Minutes
Couple or Family Sessions	There is no additional charge, the fee is structured according to time
Group Therapy Sessions	$130.00 ~ 90 Minutes
Psychoeducation Group Sessions	$150.00 ~ 2 hours (120 minutes)
Three-Day Intensive Therapy	$5,700.00 by check or cash | $5900 by credit card

I understand that Record Requests, Summary of Sessions, Consultation with Other Therapists, Psychiatrists, and other medical professionals and/or treatment providers, Letter or Report Writing, Responding to Emails and Text Messages, Crisis Communications between Sessions, and any other services provided outside the therapeutic counseling session will be charged at a rate of **$65.00 per 15 minutes to the credit card I have on file.**

Please Initial Here: _____

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 and my card on file will be charged.

Please Initial Here: _____

Involvement in a Legal Matter and/or Process Fee is $260.00 per 60 Minutes with a Minimum Charge of $260.00. 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 Dr. Hollenbeck. 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: Payment for services is due at the time services are rendered. If you file a claim with your insurance company for reimbursement and your insurance company fails to reimburse for counseling services for any reason or determines that agreed upon fees are the patient's responsibility - you are responsible for the full payment up front regardless of your insurance company's decisions.

"I have read the above fee structure 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:** _____

PLEASE READ AND SIGN the Financial Policy for Dr. Crystal Hollenbeck dba 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 or cash, 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, 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 by email immediately if this option is what you would like to do so that I can note it on your account. **I do not accept any forms of insurance and I will not communicate with your insurance company on your behalf for any reason. 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 and my qualifications. You are responsible for payment regardless of any arbitrary determination of usual and customary rates imposed by your insurance company.

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 and Rescheduling 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 and the duration of the session (For example, if you have a 90 minute session scheduled and you do not cancel within 48 hours, you will be charged for the 90 minutes.) If there is no cancellation and you do not show up for your appointment, the policy is to charge your credit card for the total amount of the scheduled session as well. Please help me serve you better by keeping scheduled appointments and/or canceling and rescheduling 48 hours prior to the scheduled time. Thank you.

By Signing Below, I acknowledge I have read the Financial Policy, I understand and agree to this Financial Policy.

Printed Client Name: _____ **Date:** _____

Printed Name of Responsible Party if Other than Client: _____

Signature of Client or Responsible Party: _____

Dr. Crystal Hollenbeck
H3 Counseling | Hope ~ Healing ~ Harmony

Mandatory Credit Card Authorization for Dr. Crystal Hollenbeck dba 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, and in the future, 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 or phone number you provide. Please provide an email address or phone number 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 email.

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By signing this form, I certify that this is my credit card and that I am legally authorized to give permission for its use. I authorize Dr. Crystal Hollenbeck to use this form and other signed policy pages in any collection process dispute. My signature further authorizes Dr. Crystal Hollenbeck dba H3 Counseling, LLC to charge my credit card an amount not to exceed the agreed upon amounts listed in the Current Fee Structure provided to me within this document in writing. I understand that I may incur additional charges if my card is declined. I will notify Dr. Crystal Hollenbeck of any changes to my account. If there is a change in the credit card I wish to use and is different from the one listed below, I agree by signing below that I give authorization for any updated credit card to be used whether I provide the updated card info in writing or verbally to Dr. Crystal Hollenbeck.

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 Dr. Crystal Hollenbeck over the course of treatment.

This authorization may be cancelled through written notice to Dr. Crystal Hollenbeck dba 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 _____ Phone _____

❑Visa ❑Master Card ❑Discover Card ❑American Express

Number: _____Exp. Date: _____/_____ Code: _____

Email Address / Phone to send receipt: _____

GOOD FAITH ESTIMATE
Informed Consent

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and / or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

All cost information and services provided are contained on previous pages of this "Individual Client Information Questionnaire Therapy Consent, Policies, and Agreements". For this reason, you are being informed of the Good Faith Estimate, but not provided a separate "Good Faith Estimate" document since all of the information that would be included in a Good Faith Estimate document is already contained herein and there are no additional foreseen costs of services outside of the information stated in the Financial Policy pages of this document and outside the scope of Dr. Crystal Hollenbeck's therapeutic license and certifications which are listed in full on her website www.CrystalHollenbeck.com. Dr. Crystal Hollenbeck is a Licensed Mental Health Therapist in the State of Florida.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. It is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy. The estimated number of sessions will be discussed with you during the initial intake session and throughout your therapeutic process. Your total cost of services will depend upon the number of psychotherapy sessions you attend. Dr. Crystal Hollenbeck offers all services by a 50-minute hourly rate of $260. She does not charge any additional amounts for specialty services like EMDR or Sex Therapy or couples and family sessions. This estimate is not a contract and does not obligate you to obtain any services from Dr. Crystal Hollenbeck. The only service Dr. Crystal Hollenbeck offers is psychotherapy in the form of in person office visits, telemental health, and three-day intensives conducted in her Orlando office.

Dr. Crystal Hollenbeck does not accept any insurance, does not offer a reduced fee and does not offer a sliding scale. All service fees are listed on page 14 of this Intake form. You will be informed in writing if the fee schedule changes, otherwise there are no adjustments to the fees. You can calculate the estimated cost by multiplying the 50-minute hourly rate of $260 by the number of sessions you schedule. Payment in full for all services is due at the time services are rendered.

A formal mental health diagnosis is not always deemed necessary or appropriate and therefore not provided to all clients. For example, clients may present to therapy for couples counseling or situational anxiety or may not meet all the criteria for a formal diagnosis. All assessment and diagnostic information will be discussed with you in the sessions and ongoing throughout your therapeutic process. Please feel free to ask Dr. Crystal Hollenbeck any questions you may have about diagnosing information.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Dr. Crystal Hollenbeck may recommend additional services such as inpatient treatment that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events.

The following Good Faith Estimate information is for your information only. Dr. Crystal Hollenbeck does not accept insurance or bill for services so the information is not relevant for private practice therapy for private pay. Again, the following information is to inform you of the information contained in the "No Surprises Act".

If your bill is $400 or more for any provider or facility than what has been outlined in the document, which is $260 per 60 minutes and $5,700 for an Intensive, federal law allows you to dispute the bill.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan or cost of treatment.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Please keep a copy of this Good Faith Estimate information in a safe place or take pictures of it. You may need it if you are billed a higher amount.

My signature below represents that I have read and understand this Good Faith Estimate Informed Consent. I understand that Dr. Crystal Hollenbeck does not negotiate her rate for any reason and I am responsible to pay for therapy services rendered in full at the time of services. I understand Dr. Crystal Hollenbeck does not offer any billing services and does not accept any insurance. I understand that Dr. Crystal Hollenbeck will discuss diagnosis information as necessary in the therapeutic process and that I may ask her any questions related to cost, diagnosis, and treatment planning at any time during treatment with her.

Printed Client Name: _____

Client Signature: _____ **Date:** _____

MEDICARE INSURANCE
Informed Consent

Are you enrolled with Medicare? Yes____ No____

If you are currently enrolled in Medicare or enroll in Medicare in the future, kindly note that Dr. Crystal Hollenbeck, operating as H3 Counseling, LLC, is not enrolled with Medicare, does not participate in Medicare, or accept Medicare. Dr. Crystal Hollenbeck dba H3 Counseling, LLC is not affiliated with Medicare panels and has chosen to opt out of Medicare as of 01/01/24 and does not plan to opt in when the 2 year opt out period expires but will renew the opt out option automatically. Dr. Crystal Hollenbeck dba H3 Counseling, LLC operates on a fee-for-service basis, all clients are private pay which requires payment directly from clients for therapy services at the time services are rendered. If you have Medicare, you can find a therapist who accepts it, you do not have to continue counseling with Dr. Crystal Hollenbeck. If you choose to meet with Dr. Crystal Hollenbeck, you will be responsible for the full payment.

As a result, you will not be able to seek reimbursement for therapy sessions with Dr. Crystal Hollenbeck dba H3 Counseling, LLC through Medicare if you are enrolled with Medicare now or in the future.

Please sign here to indicate that you understand and agree to this:

Printed Name: _____ Date:_____

Client signature: _____