

Revised 8/8/17

TRAHAN COUNSELING

631 Mill Street, Suite 101, Houston, TX 78640

Client #1 Information

Date: _____

Name: _____

Phone (hm): _____ (wk): _____ (cell): _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Is it okay to send information regarding counseling, billing, etc. to the above address? _____

May we confirm appointments by contacting you at the information above? _____

What is the best way to contact you for confirming appointments? _____

Emergency Contact (include phone): _____

Sex: Male _____ Female _____ Date of Birth: _____

Psychiatrist: _____ Phone: _____

List any significant health problems: _____

List medications currently taking with dosage: _____

Employer: _____ Occupation: _____

Have you ever seen a counselor or psychotherapist before? _____

If yes, when and with whom? _____

Give a brief description of the treatment and outcome: _____

How were you referred to this office? _____

May we contact the referral to thank them? _____

Brief reason for seeking therapy at this time: _____

Note: Trahan Counseling requires for each client to have a credit card on file. Please fill out the information required below:

Name on credit card: _____ Card #: _____

Expiration date: _____ CV number (3 digit on back of card): _____

Cardholder zip: _____

All credit card and personal information is held in accordance with standards outlined in the Health Insurance Portability & Accountability Act and remains confidential.

Revised 3/27/16

TRAHAN COUNSELING

631 Mill Street, Suite 101, Houston, TX 78640

Client #2 Information

Date: _____

Name: _____

Phone (hm): _____ (wk): _____ (cell): _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Is it okay to send information regarding counseling, billing, etc. to the above address? _____

May we confirm appointments by contacting you at the information above? _____

What is the best way to contact you for confirming appointments? _____

Emergency Contact (include phone): _____

Sex: Male _____ Female _____ Date of Birth: _____

Psychiatrist: _____ Phone: _____

List any significant health problems: _____

List medications currently taking with dosage: _____

Employer: _____ Occupation: _____

Have you ever seen a counselor or psychotherapist before? _____

If yes, when and with whom? _____

Give a brief description of the treatment and outcome: _____

How were you referred to this office? _____

May we contact the referral to thank them? _____

Brief reason for seeking therapy at this time: _____

Note: Trahan Counseling requires for each client to have a credit card on file. Please fill out the information required below:

Name on credit card: _____ Card #: _____

Expiration date: _____ CV number (3 digit on back of card): _____

Cardholder zip: _____

All credit card and personal information is held in accordance with standards outlined in the Health Insurance Portability & Accountability Act and remains confidential.

Client Information and Service Agreement

Consent and Responsibility Statement

Initial each section and sign

_____ *Counseling Services*

I hereby seek and consent to participate in counseling with Lisa Trahan, PhD.

I am aware that the practice of counseling, psychotherapy, and coaching is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results and procedures provided by Lisa Trahan, PhD. Counseling often depends upon the personalities of the therapist and client and the problem being examined. The counseling process is not like seeing a medical doctor; greatest outcomes will be determined by willingness and work that is completed inside AND outside of sessions. There may be assignments, meetings, etc. suggested by the counselor outside of session time. Participation in these suggestions will maximize success but are not a guarantee.

Counseling has both benefits and risks. Risks may include uncomfortable feelings, such as sadness, anger, guilt, anxiety, loneliness, and helplessness. Counseling may require recalling unpleasant memories from one's history. Counseling has been shown to provide benefits for those who utilize it. It often leads to a decrease in distress over problems introduced, better relationships, and an increase in personal confidence. There are no guarantees that this will happen.

_____ *Professional Fees:*

The regular hourly rate for couple sessions is \$120, unless adjusted or modified by your therapist. We can provide counseling on a sliding fee scale provided there is a need. A fee will be contracted between you and your therapist. You will be expected to pay this fee upon service. It will be your responsibility to inform us if you do not want for us to send an invoice to you at the address you have provided. If you want a receipt for submitting to your insurance, please request it. Please note that all receipts for insurance contain personal information about your therapy, including a diagnosis.

In addition to fees for weekly appointments, it is our practice to charge this amount on a prorated basis for other services that you may require. These services may include paperwork review, assessment writing, phone

consultation lasting longer than 5 minutes, consultation with other professionals that you have authorized, or preparation of records that have been requested by you. It is the practice of this office to avoid becoming involved with testifying or writing reports for litigation or court cases, except in unusual or exceptional circumstances. If these circumstances should arise, fees of \$350 per hour will be expected for professional time. This fee includes travel time to and from legal meetings and court.

Regarding Insurance: Lisa Trahan, PhD, may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the time of service, and the staff will bill the insurance company for the balance. When we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. We are providing you with an estimate of your share of the cost of treatment as provided to us by your managed care company, insurance company, or employee assistance program (EAP). Sometimes this information is not consistent with later information we receive from the insurance company. Your actual share may be more than this estimate. You are ultimately responsible for the charges. Remember to please let me know if you change insurance or managed care companies.

Managed Care Companies: Many insurance companies contract with a managed care company to manage the benefits and care. The managed care company may require that we obtain prior authorization for sessions, and we are usually required to submit clinical information about you to do so. By initialing above, you authorize us to bill your EAP or Managed Care Company, and you authorize the payer to pay me directly.

Credit Card Payments

If you choose to make payment using a credit card, please be aware that we use Square, a credit card payment service, to process your payment. It is the practice of Square to email a receipt to the account holder using a stored email address. Please be aware that if you share a credit card account with someone, s/he may receive an emailed receipt of payment for our service. Square charges a fee for service, which amounts to approximately \$4 per transaction. As such, we ask our clients to pay \$2 for each transaction, and we pay the remaining balance.

Appointment Scheduling and Cancellations

This office requires 24-hour advanced notice of cancellation of appointments. If you do not appear for a scheduled appointment, you will be charged the regular hourly rate, unless you have provided 24-hour cancellation notice. If using insurance, the regular hourly rate is the contract rate for your insurance plan, which you will be responsible for in full. Your insurance plan cannot be billed for missed appointments.

Electronic Communication (E-mail)

By initialing here, you are agreeing to receive email communications from Trahan Counseling. These communications may include appointment reminders. Please note that Trahan Counseling does not engage in the practice of transmitting protected health information pertaining to clients by email, as we cannot ensure that such transmissions are completely protected and secure.

Electronic Communication (Texting)

It is not the practice of Trahan Counseling to communicate with clients via texting. If you choose to text Lisa Trahan, PhD, please be aware that texting is not a secure form of communication, and we cannot ensure the security of your message.

Social Media

Trahan Counseling does maintain a social media presence. Additionally, Lisa Trahan, PhD, has personal social media accounts. In order to protect your personal privacy and anonymity, we will not engage with you using social media. If you have a special circumstance pertaining to social media, please discuss this with us when you begin counseling.

Confidentiality

In regards to confidentiality, all communications and client files are held in confidence between therapist and client by law. In order for information regarding your treatment to be released, you must give written permission. There are exceptions to this in cases such as:

- Judicial proceedings in which the judge specifically requests records of treatment. These cases usually occur in situations such as child custody proceedings where a judge must make a decision based upon an emotional condition. This therapist has the right to refuse to release documents to an attorney unless requested by a judge.
- If the therapist believes that a child, an elderly person, or a disabled person is being abused. In this case, the therapist is required by law to file a report with an appropriate state agency.
- If the therapist believes that the client intends to bodily harm another human being, in which case the therapist may take actions such as contacting the police, notifying a victim, or seeking appropriate hospitalization without consent of the patient.

- If a client intends to commit harm to him/herself, a therapist may be required to seek hospitalization in order to protect life or to contact family members who can arrange such means.

If actions such as these are required, the therapist will attempt to make every effort to discuss it with the client first.

Lisa Trahan, PhD, may find a need to consult with a colleague during the course of your treatment. All identifying information regarding your identity will be eliminated and avoided to maintain your confidentiality.

Special Relationship Between Therapist and Client

The relationship between a therapist and client is a special one. Based on the ethical guidelines of psychology, the therapist must avoid any and all possibilities of a dual relationship with the client. Therefore, a therapist may not be friends, colleagues, or practice any business with a client due to a conflict of interest. Contact outside of the practice of counseling is off limits. This protects the interest of the client and insures that conflicts of interest do not arise. This means that the therapist cannot attend special events, such as graduations, birthdays, parties, or any other event that the client may request. If the therapist sees a client outside of therapy by chance, the therapist will not approach the client, identify him/herself, or identify the relationship. If a client determines that s/he may want to address or approach a therapist, s/he may do so; however, it will be by the client's choice. Please do not be offended if the therapist avoids contact in public places due to this limitation with ethical guidelines. It is to protect your confidentiality and this special relationship.

Spirituality

Some people want to have their religious or spiritual beliefs integrated into their counseling. If you would like this, please initial.

Research and Training

Because of the uniqueness of each psychotherapy treatment, I agree that the treatment contents may be used for training and/or educational purposes with strict confidence. This may include, but is not limited to, video, assessment measures, and clinical notes. I also understand that the therapist reserves the right of publication related to the treatment process in order to provide research data to support practice methods. I understand that personal identification such as my name will not be revealed if any materials are to be used for such purposes.

Client #1 Name:

I, _____ (full name),
have read and agree to the conditions of this contract.

Signature (Client #1)

Date

Therapist

Date

Client #2 Name:

I, _____ (full name),
have read and agree to the conditions of this contract.

Signature (Client #1)

Date

Therapist

Date