CLIENT INTAKE FORMS
ABOUT OCD CLINICS

Please initial each box:

☐ I understand that OCD Clinics utilizes Professional Counselors and/or Interns licensened in the state of Texas

☐ I understand that OCD Clinics works with children, adolescents, and adults in individual, group and family counseling.

☐ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

☐ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

☐ I understand that if I am concerned about slow progress or lack of progress, I have the right to speak to my therapist about this.

☐ I understand that my therapist does not perform formal testing but refers individuals to those who do.

☐ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

☐ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct my therapist to tell someone else in writing or verbally, b) My therapist determines that his client poses a threat to themselves or others, c) he is ordered by a court to disclose information, or d) He suspects that child abuse has taken place, at which time he will notify Child Protective Services.

☐ I understand that counseling can improve as well as upset the equilibrium in any person or family.

☐ I understand that if I have a complaint I cannot resolve with my therapist and I wish to file a formal complaint, I may contact the Texas Sate Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

☐ I understand that there is a returned check fee of $50 and that if a returned check is not cleared up in 30 days, my therapist will file a suit with the Comal County District Attorney's Office.

☐ I understand that if I do not give at least 24 hours notice in canceling an appointment, I will be charged a fee equal to that of the scheduled appointment.

☐ I understand that my therapist is not a psychiatrist and as such cannot recommend or prescribe medications but can encourage clients to see an MD for a medication evaluation.

☐ Emergencies: I understand that although OCD Clinics does not provide formal emergency services, it does wish to be available to the extent possible. I may call the office number at any time and leave a message. If during the business day, this call will be returned fairly quickly in most circumstances. If the call is received over night or on the weekends, it will usually be returned the next business day. If I find myself in an urgent situation, I have the choice of waiting for the return call, of calling 911, or of going to the nearest emergency room for immediate care.

☐ Death or Incapacity: I understand that in the event OCD Clinics becomes unable to continue providing clinical services, Jay L Jeter, LPC-S, will be designated as conservator for my patient records and will take possession of said records at that time. Upon receipt of my written request Jay L. Jeter, LPC-S, will make these records available to me or a mental health provider of my choice.

By signing below, I confirm that I have read and agree to the above information.

_____ _____

Client/Parent of Client ***Date Received and Read***

OCD CLINICS

PRE-AUTHORIZATION FOR HEALTH CARE

CONSENT FOR TREATMENT

By signing this document, I, _____, am indicating that I agree to participate in the following services with OCD Clinics

____	CLINICAL ASSESSMENT	____	INDIVIDUAL THERAPY
____	CLINICAL ASSESSMENT FOR MY CHILD	____	THERAPY FOR MY CHILD
____	FAMILY THERAPY OR COUPLE/RELATIONSHIP THERAPY	____	GROUP THERAPY
____	OTHER _____		

I understand that, in order to develop the therapist-patient relationship and treatment plan necessary to meet my needs, an initial assessment will be completed and a joint decision made to either proceed with the recommended treatment plan or to continue the assessment over additional visits. The limitations and benefits of all therapy or services I may receive will be discussed with me. I understand that while the long term goal of therapy is to feel better, I may experience a period of feeling worse before I begin to feel better and I also understand that there is no guarantee of success. I understand that there may be alternative methods of therapy for my consideration and I am encouraged to ask questions regarding my treatment or other methods at any time.

PRIVACY (CONFIDENTIALITY) POLICY

State and federal laws protect the confidential nature of the therapist-client relationship. Clinical information will not be released to anyone without prior written consent to do so by the client (or the guardian-parent of a minor). Interaction between client and therapist will occur ONLY during the session. Other interaction is prohibited by the Code of Ethics; text and email messages by other clients or collateral contacts will be ignored. For billing and scheduling questions, please contact the office at 830-515-8480. However, there are some exceptions where information may be released without client consent. Instances where information may be revealed include:

1) A therapist must take appropriate action when there is a danger to the client or to another individual at the client's hands. In general, this means that the therapist may involve others to protect the client if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival. Others may also be involved to prevent harm to another person. State law mandates that suspected neglect or abuse of a child, of an elderly individual, or of a disabled individual must be reported.
2) When ordered by a court to do so, a therapist may testify or release client records. However, no release of information or testimony is given in response to a subpoena without the client or client guardian's written authorization unless required by law to do so.
3) Consultation with other health care professionals may be necessary at some point in time. Where possible, identification of clients is withheld. However, there are times when exchange of information is necessary. An example of this type of exchange would be when the therapist is out of town or on vacation and another therapist is providing coverage for that therapist. Case material is often used for training, for research, and for other academic endeavors but client identification is always removed. Any other release of information must come with the above listed written approval.

I understand that this agreement is valid for the duration of time that I am participating in services with OCD Clinics. By signing below, I acknowledge that I have received a copy of the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy*** , and I understand and agree to the entire contents of those documents. I acknowledge that I have had an opportunity to have answered any questions, comments or concerns that I might have had prior to signing this consent and participating in services. I am aware that I can stop counseling at any time. OCD Clinics reserves the right to amend the ***Pre-Authorization for Health Care*** and the ***Privacy (Confidentiality) Policy*** and changes will be available at the office of OCD Clinics.. I can request a copy of changes at any time at no charge. Any changes that OCD Cliics makes are effective immediately unless otherwise indicated. ***A copy of this page may be found on the last page for your records.***

_____ _____

CLIENT SIGNATURE (18 and older) Date

_____ _____

SIGNATURE OF PARENT OR SPOUSE
(for a child age 17 or younger Date

COMPLAINTS

It is always my goal to provide professional and ethical services. If you are ever dissatisfied with my services, I encourage you to discuss it with me first to see if I can resolve your concern. However, if that is not satisfactory to you, you are also welcome to contact the Texas State Board of Examiners of Professional Counselors at the following address: 1100 West 49th Street Austin, Texas 78756-3183 1(800) 942-5540

NOTICE OF FINANCIAL RESPONSIBILITY

I understand that the rates for this OCD IOP treatment plan is as follows::

$3,850 per week which includes daily check-ins and two follow up appointments. Second and Third weeks may be eligible for a 10% discount.

I am responsible for paying these rates at the time of my session.

I understand that OCD Clinics does not work with or bill any insurance company for these services. Receipts can be provided to me which I may choose to submit on my own behalf.

If I do not give 24 hours notice of a cancellation or if I miss my appointment, I will be charged the full session fee. This notice must be during the Monday to Friday workweek, not over a weekend

I understand that payment may be made with cash, credit card, or by check. OCD Clinics does not extend credit. OCD Clinics does not depend on an outside collection service unless accounts are overdue by 90 days. OCD Clinics would much rather communicate with patients and find solutions to overdue accounts. I hereby consent to the delegation of collection activities to an outside collection agency, including the release of necessary information required by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. There is a returned check processing fee of $50 in addition to reimbursement for charges assessed by the OCD Clinics bank. Statements, receipts, or other documentation will not be issued to any delinquent account until paid in full. Payment by credit cards will be in accordance with the **Pre-authorization for Health Care** form provided by OCD Clinics. I agree that OCD Clinics reserves the right to amend this agreement and may provide me with written notice of any amendment, at which time I will have 30 days to decide if I will continue services with OCD Clinics under the amended agreement.

COURT APPEARANCES: I understand that if report preparation is requested or required, the time rate charged for our therapy sessions will apply. Extended or frequent telephone contact will also be charged for. I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350.00 an hour for any preparation and attendance at any legal proceeding. Professional fees for court appearances, depositions and attorney consultations including travel and waiting time, are non-discountable, and are payable in advance only. A four hour minimum ($1400) is required and must be paid prior to any testimony, provision of a clinical opinion, response to attorneys via telephone call or mail, subpoenas, or preparation of any report for litigating parties.

_____ _____

Signature of client or Parent of child under 17 Today's Date

CREDIT CARD INFORMATION AND AUTHORIZATION

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be charged at my full hourly rate. If I do not hear from you before your missed appointment, your credit card will be charged. If you need to cancel or are going to be late, please call me at my office number (830-708-0114). If you arrive late, the session will still end at the scheduled time. If I haven't been informed that you will be late and you haven't appeared 15 minutes after your scheduled time, I may leave the office.

Credit Card Authorization Form

I, _____, hereby authorize OCD Clinics to bill my credit card as listed below for professional fees for [ ] myself or _____.

I agree that OCD Clinics may bill my credit card at the full fee of $_____ for professional services including the following:

(Initial)
_____ Appointments that I elect to pay by credit card.
_____ Missed appointments. (Will be charged at the full fee)
_____ Appointments I have cancelled with less than 24 hours' notice. (Full fee)
_____ Telephone consultations (billed in 15 minute increments based on $140 per hour)

I also agree that my credit card may be charged for the following:
_____ Insufficient funds/returned checks and bank charges for those.

Type of Card: (check one):

[ ] Visa [ ] Mastercard [ ] Discover [ ] American Express

Name as it appears on card: _____

Card Number: _____

Expiration Date: _____

CVV2/CID Security Code: _____

Zip code on billing address: _____

Signature: _____

Date of Signature: _____

Charges will appear on your credit card statement as OCD Clinics or some variation of it.

OCD CLINICS

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