Hanna Del Toro, LCSW
9414 Anderson Mill Rd. #205
Austin, TX 78729
Phone (512) 797-5871 Fax (512) 774-6132

CLIENT & COUNSELOR AGREEMENT

Name of the Client:_____ DOB:___/___/___
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone Number:_____
Additional Phone Number:_____
Email Address:_____

Household members: List name, relationship & DOB/Age:
_____
_____
_____
_____

Guardian's names, relationship, address (if different from above) and phone numbers:
_____
_____

Referral Source:_____ Referral's Phone Number (if applicable):_____

Primary Care Physician's (PCP) Name:_____ PCP Phone Number:_____

Secondary Physician's Name:_____ Physician Phone Number: _____

Emergency Contact (name, relationship & phone number):_____

Please list any medical/mental health conditions and medications you are currently on:
_____
_____
_____
_____

1. Name of the Primary Insurance Co (on the front of the card): _____
Name of the Behavioral/Mental Health Subcontractor (usually on the back of the card):_____
Customer Service Phone Number for Providers (for Behavioral/Mental Health):_____
I.D. Number (on the front of the card):_____Group #:_____
Relationship to Client:_____
Billing Address (on back of card):_____
City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Relationship:_____ DOB: ___/__/___

2. Name of Secondary Insurance Company, if applicable (on the front of the card): _____
Name of the Behavioral/Mental Health Subcontractor (usually on the back of the card):_____
Customer Service Phone Number for Providers (for Behavioral/Mental Health):_____
I.D. Number (on the front of the card):_____Group #:_____
Relationship to Client:_____
Billing Address (on back of card):_____

City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Relationship:_____ DOB: ___/__/___

_____(initials for legal guardians of clients) Consent for Participation in Counseling – By initialing to the left and signing below, I verify that I am the parent or legal guardian of the above-named minor, and that I have the legal right to give consent for the above-named minor to participate in counseling sessions conducted by Hanna Del Toro, LCSW.

_____(initials) I hereby authorize Hanna Del Toro, LCSW to share information to my insurance companies concerning the client's diagnosis and treatment. I hereby authorize Hanna Del Toro, LCSW to provide treatment for me and/or my dependents. I authorize payment of therapeutic services to Hanna Del Toro, LCSW.

_____(initials) It is the responsibility of the patient to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible. If you do not inform of us of the changes, you agree to pay for all fees not covered by your current or previous insurance companies.

_____(initials) In the event of an emergency I give permission to contact my emergency contact listed above in relation to the emergency only (which include hospitalization, medical emergency, need to contact EMS and/or police by clinician during crisis).

Fees for services are as follows:

- Addictions Assessment $_____
- Individual Psychotherapy $_____
- Documentation $_____

All fees (co-pays, co-insurance payments, etc.) are due and payable at the time of service.

If you are a private paying client, you agree to pay $_____ per session at the time of the service.

_____(initials) **Cancellation Notice**: There is no charge for cancellation of appointments if notice is given more than 24-48 hours in advance with reasonable cause. An administrative fee of $75.00, or full session fee, will be charged if you give less than 24-hours notice. This fee is not covered by any insurance companies. Exceptions to this may be made on a case-by-case basis for emergencies such as weather related events, illness, loss in the family, etc. Should your therapist need to late cancel for the same reasons every effort will be made to get you a same week appointment time.

_____(initials) Additionally, if for any reason you have to cancel your appointments for two consecutive sessions, your reserved appointment time may be released. However, every effort will be made to re-schedule your appointment based on your therapist's availability.

_____(initials) I understand that if I am more than 15 minutes late, the session will be considered a late cancel and I will be charged the full late cancel fee.

_____(initials) **Appointment Reminders by text or email (optional):** I consent for Hanna Del Toro, LCSW to create a password and login in the software program by therapyappointment.com in order to receive appointment reminders by TEXT or EMAIL (circle one). My cell phone carrier is:_____ and my cell phone number to receive the text is: _____. My email address for an email is:_____

_____(initials) **Court:** I do not testify in court as a witness. If you are seeing me for marital therapy or if there is a custody dispute, I will not be available for court testimony for either party. In rare circumstances, where I might be required to testify in civil court by subpoena, I will require payment in advance of $125.00 per hour during the entire time at the court or at the depositions, including travel time. If my case includes a possible subpoena I will supply credit card information that I understand will be billed this rate in the event my counselor has to attend court.

_____(initials) **Phone Calls:** After 10 minutes of phone contact there will be a $1 a minute charge.

_____(initials) **Assessment Information (for assessments only, no need to initial for only counseling services):** In addition to the limitations mentioned below, I understand that if I am referred by a professional association, licensing board, employment, or legal entity for an assessment, I will need to sign releases for these entities and the information obtained during the assessment process will be shared accordingly. I also understand that additional consents may be requested in obtaining collateral information specific to my case.

_____(initials) **Assessment Revocation of Consent(for assessments only, no need to initial for only counseling services):** I understand that should I decide to revoke consent for communication in an assessment process, that I will be 100% responsible for the cost of the assessment process.

_____(initials) **Confidentiality:** Information that you discuss with your therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations. This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for therapeutic purposes, in case of a minor). However, there are limits to confidentiality under any of the following circumstances:

1. If a court of law orders your records.
2. If you threaten to harm yourself.
3. If you threaten to harm others.
4. Reports of abuse of children and/or elderly individuals
5. If you are using a mental health insurance policy to pay for your visits, we may be required to provide certain diagnostic and treatment information in order to obtain payment for our services.
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations. You may ask for a copy of the HIPAA regulations at any time. Additionally, there is a copy of the HIPAA regulations posted in the therapist's office or in the waiting room.
7. Please be advised there is a risk that a breach of confidentiality could occur should you choose to text or email Hanna Del Toro, LCSW by phone or on-line. To decrease the risk of breach of confidentiality, verbal contact by phone is recommended.

_____(initials) **Consultation:** At times this clinician may seek consultation for your case. Should consultation be sought no identifying information will be provided including: name, age, date of birth, social security number, identifying physical characteristics, associations, or any information that would lead to recognition of you as a client at this practice.

_____(initials) **Referral Policy:** Referrals will be provided for clients to professionals in the community when this practice is unable to best meet the needs of the client.

_____(initials) In the event that my therapist, Hanna Del Toro, LCSW becomes incapacitated or deceased, I understand I will be notified via Hector Del Toro, LPC-S who will access my contact information only in the events mentioned above.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with your therapist.

Client Signature:_____ Date:_____

Legal Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____