Theodore A. Carlos, M.A.
Licensed Professional Counselor

Welcome to my practice! Before we get started, I have a few pages of information that I need you to read and some forms to sign. This will take about 15 minutes and is necessary to make our professional relationship run smoothly. Please feel free to call me should you have any questions.

Appointments

All sessions are by appointment only. Because I work with kids and families, I offer evening and weekend office hours. Tuesday-Friday 10AM-6:30PM (ending by 7:30PM) and Saturdays 10AM-4PM (ending by 5PM). Appointments run 45-50 minutes long and will start and end within 15 min of a scheduled appointment time. For the sake of time management, I ask that have your payment ready at the beginning of the session.

Set Repeated Appointments. Sometimes setting up a set weekly or biweekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically tell me you would like to give it up. If two set appointments are missed, I will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times.

Missed Appointments

I have a very strict policy. A full **24-hour notice is required to cancel an appointment** to avoid being charged my full rate of $120. It cannot be billed to an insurance carrier. I understand that emergencies and health problems do come up and I am willing to consider them when adequate notice is not given. However, No-shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not be considered.

Communicating with Me

• *I do not offer "Crises intervention" or "emergency services". Please call **911 or (512) 454-3521** for that kind of emergency*. The average time to get an appointment is 24 hours but I often see people the same day they call. I am available by cell phone after hours and between sessions for non -emergencies for up to 10 minutes w/o charge at: **512 789-3382.** That number will also accept confidential voice and text messages. If you do not hear back from me in 8-12 hours, please feel free to call again in case my phone failed notified me of your call.

• I will exchange emails with clients. However, clients need to give me a signed statement that they agree to it and that any email sent to them is password protected and on an internet site such as yahoo or hotmail, etc. I cannot be responsible for breaches in confidentiality resulting from someone getting your password. My email is: "**tedcarlos@mac.com**". I respond to emails within 24 hours. I do not provide extensive or regular emails as part of anyone's therapy and reserve the right to decline to deal with some issues over email. Please talk to me about this should you have any questions. Other valuable information can be obtained at our website: **www.spicewoodgroup.com**.

I am occasionally available for: court and legal, school, and hospital consultations though all time taken from seeing regular appointments at my office will be part of the hours that will be billed.

Our confidential **Fax # is: 512 345-8083**. Please indicate if your fax is confidential and if you can receive confidential faxes. Please include a cover sheet that say's "confidential" for all faxes.

Confidentiality

Therapy is a very private matter and I am very careful about my client's confidentiality. (See Summary of Privacy Practices on p.8) I would ask that my clients be very careful about discussing their therapy as well. You don't have to talk about it with friends and family members, but it is "OK" to ask them to respect your privacy in this matter. If you see someone in our office that you know, please also respect their privacy.

I understand and accept these terms as conditions of our professional relationship.

_____

Please sign and date

New Client Data Sheet

Please fill-out all that applies

Check if also the insured [ ]

Client Name: _____

Client Date of Birth:_____ Client Social Sec#_____

Address:_____

_____ Zip Code_____

Home Phone Number:_____ Work/Other Phone Numbers:_____

Email Address (if have one):_____

Place of Employment / School Name:_____

Occupation / Grade_____

Spouse or Partner (if applies):

Check if also the insured [ ]

Name: _____

Date of Birth:_____ SS# _____

Work/Other Phone Numbers:_____

Email Address (if have one):_____

Partner's Place of Employment / School Name:_____

Occupation:_____

Place of employment: _____

Family:

Children or Sibling's Name(s) (if applies):

_____ Age:_____

_____ Age:_____

_____ Age:_____

Parents (please circle if applies): Married Separated Divorced

- If separated or divorced, describe custody (attach legal papers if necessary) _____

_____

- If divorced and this is for a minor under 16 years of age, describe who can give consent for treatment? _____

_____

I am legally allowed to give consent for treatment and hereby do so:

(Please sign and date) _____

All information disclosed on this form will be held in accordance with Federal Confidentiality Standards

Clinical Information

(Parents may fill this out for minors if necessary)

Who referred you to my practice?_____

What led you to seek therapy at this time? _____

_____

How long have you had your current problems?_____

_____

What do you hope to gain from therapy?_____

_____

Do you (or is the child or adolescent) feeling like hurting yourself (themselves) or others at this time? (circle)
Yes / No

Have you (or the child or adolescent) felt like hurting yourself (themselves) or others in the past year? (circle)
Yes / No

Have you (they) been hospitalized for any mental or emotional problem? (circle)
Yes / No

Are you (they) taking any medication at this time? What dose? Who is the doctor prescribing the medication?

_____

_____

_____

_____

Family Doctor_____Phone Number_____

Other Doctors_____Phone Number_____

Client or family history of mental or emotional problems/previous treatment/diagnoses:_____

_____

_____

_____

Do you want me to contact your doctor(s)? (circle) Yes / No (If yes, separate form required)

Are there any legal issues concerning your pursuit of therapy (Child Custody, Divorce, employment, school, or court requirements)? If yes, please explain:_____

_____

_____

Is any Attorney, Court, School, or Employer requiring documentation of any kind regarding your therapy? If yes, please explain: _____

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Financial Arrangements

Please fill this form out completely and return it to me before your first appointment

The financial part of seeking therapy is everyone's (including mine) least favorite part of this process. However, because this is a professional relationship, I have found that it is highly important to make sure that all practical and financial arrangements, agreements, and expectations are made before we get started. Therefore, I ask that all new clients read this carefully, sign it at the bottom of the page, and return it to me before your first appointment. I cannot see a new client until this information is completed.

Fees/Payment Agreement

Clients / Parents or Guardians are responsible for payment for all services rendered. Payment or co-payment is expected at the beginning of the session. I accept cash, check, and most credit cards. I may be willing to accept delayed payment as long as those arrangements are made in advance. Balances over 30 days are subject to 12% annual interest. Balances over 90 days are subject to collection actions. There is a $20 fee on all returned checks or credit card charge backs.

Except where I have a contractual agreement with an EAP or insurance carrier, my fees are as follows:

Evaluations, Marriage, Family, and Relationship Counseling	$150.00hr
Individual Counseling:	$120.00hr
Phone consultations (over 10 minutes in length billed in 15 minute intervals)	% of hourly rate
Court consultation (billed for all time away from office or time I cannot schedule clients)	$200.00hr

For uninsured clients, I offer sliding scale fees for clients in financial need, but this is generally offered after I have evaluated the person's ability to pay. If a client's ability to pay changes, this negotiated fee is subject to also change to give other clients the ability to afford services.

For insured clients, I will make fee adjustments according to my contract with an insurance carrier. Any contractually agreed charges that are not paid are the responsibility of the client or responsible party. If I do not have a contract, my full fees will be charged. Anything not paid for by the insurance company is charged to the client or responsible party. If authorization is required by your insurance company, you are responsible to track with the number of authorized sessions used and must take part re-authorization prior to your last authorized session.

I am willing to help file your insurance. However, please remember, I do not work for any insurance companies. I work for my clients. Accordingly failure on the part of your insurance company to honor any payment agreement, process an authorization request or claim, add unexpected limitations to your policy, etc. leaves you, responsible for any unpaid charges. In Texas, timely filing and response is defined as 30 days. I am willing to file claims and report any delinquencies to the Texas State Board of Insurance on your behalf, but you are ultimately responsible for unpaid charges.

By signing this form, I acknowledge and understand these policies.

_____ Date_____

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Credit Card Information

Please provide the your credit card information if you plan use to make payments on your account or for no-shows and missed appointments without giving agreed notice:

Type of Credit Card (circle): ••••••Visa•••••• Master Card • ••• • American Express

Name as printed on card:_____

There is an additional $2.00 charge for Amex. I do not accept Discover cards

Credit Card Number:_____

Expiration Date:_____

3-4 Digit Security Code on Back of Card: _____

Billing address for credit card (if different than address already given):_____

By my signature below, I grant Theodore Carlos, M.A., LPC. my permission to charge the account described above.

_____ _____

Signature Date

Printed Name: _____

Optional automatic payment agreement

If you would like your credit card billed monthly for any outstanding balances (including missed appointments, claims not paid, and bounced checks), please sign the permission below.

By my signature below, I grant Theodore Carlos, M.A., LPC. permission to charge the account described above for any outstanding balance on a monthly basis.

_____ _____

Signature Date

Insurance Information

Filing insurance has become so complicated and problematic that many mental health providers have refused to participate in insurance company's panels. Rather than not participate, I have decided to ask for more information before I agree to file insurance for clients. I also now require that clients take a more active role in filing their claims and/or pay for their insurance company failing to pay a claim.

Do you plan to file insurance for your treatment? (circle) Yes No

(If no, please circle and skip to the **next** section. If so, please line through any questions already answered and complete the rest. All the insurance information and signatures are necessary for a clean claim. Failure to provide it may result in a claim denial.)

Patient relationship to insured: Self ••••• Spouse •••••Child••••• Other (explain)_____

Insured Name: _____

Insured Date of Birth: _____ SS# _____

Address: _____ Zip Code _____

Home Phone Number: _____ Work/Other Phone Numbers: _____

Email Address (if have one): _____

Place of Employment (necessary to file claim): _____

Insured ID Number (on card) _____

Group Number (on card) _____

Insurance Company Name /Address /Phone Number/Payer Number where claim is to be sent (usually on insurance card) _____

_____

Is there a secondary insurance? (circle) Yes No (if so, a second form must be filled out)

Assignment of Benefits

I authorize payment of insurance benefits to Theodore Carlos, LPC. (circle) Yes No

If no, I would like to pay for my sessions and receive reimbursement from my insurance company

_____

Name Date

I want my insurance company to send checks to me and I will pay Mr. Carlos's fees at the time of service.

_____

Name Date

Medical Release Statement

I authorize the release of any clinical or other information necessary to process my insurance claim.

Signature _____ Date _____

Printed Name

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Insurance Verification Questionnaire

Please use this form call your insurance company to get a clear view of your benefits. Behavioral health claims are often filed differently than your regular claims and have different benefits. It is important that you ask ALL of the questions or you could be responsible for a claim denial. Insurance companies usually only offer automated messages or read a script and fail to provide all the right information to file a claim. If possible try to speak to a representative and make sure they answer all your questions. Remember, you paid for the coverage and are entitled to this information.

Phone number you called:_____Name of person you are you speaking to:_____

Do they represent your actual insurance company or another company that handles your behavioral health claim claims?_____

Is your therapist's name listed as a provider? (Circle) Yes No

Is there an ID number for this therapist that needs to be on the claim? (Circle) Yes No

If so, what is that number?

Is authorization/certification required for out patient benefits? (Circle) Yes No

If so, what is the authorization number?_____
(Note, they may say it will be mailed, but get it anyway to prevent delays in the claim)

If so, how many sessions are authorized? (Please ask for 10) _____

Between what dates are the sessions authorized_____

Is there a deductible? (Circle) Yes No If so, how much? $_____

If so, how much has been met as of today's date? $_____

How many sessions are allowed a year? How many used this year?

What is the co-payment for a mental health claim?_____

Are mental health claims sent to a different place than other medical claims? (Circle) Yes No

If so, what address should it be sent to?_____

Is there an electronic payer number?_____

Does your policy have a pre-existing condition exclusion? (Circle) Yes No

Do they require written documentation that your sessions with me are not pre-existing before processing a claim? (Circle) Yes No

Are there any diagnoses or types of treatment limited on your policy? (DSM or CPT codes)

(Circle) Yes No What codes are exempt?_____

Please list any other limitations on your policy.

I understand that I am responsible for any unpaid charges claim resulting from my insurance company failing to provide any information related to filing a claim.

Please sign and date:_____

All information disclosed on this form will be held in accordance with Federal Confidentiality Standards

Summary Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED . PLEASE REVIEW IT CAREFULLY

My Commitment to Your Privacy

My practice is committed to maintaining the privacy of your personal health information. Confidentiality is essential to my profession. I will only use the information that I get from you to provide you with treatment, to arrange payment for my services or for some other health-care operations. If either you or I wish to share your information for any other purposes, I will discuss this with you and ask you to sign a release.

Please note: State and federal laws may require disclosure in legal situations such as:. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat or when:

1. When a judge requires disclosure, such as in lawsuits and legal proceedings.

2. A law enforcement official requires me to do so.

I have read and understood the information on this sheet.

Signature_____ Date _____

Printed Name_____

I can also release specific information with your written consent. This includes: family members, schools, state officials, insurance companies, medical doctors, and other mental health providers. I will need a separate form for each person. Please sign the document on the next page if you want me to communicate with someone and ask for additional forms if more than one is required.

Theodore A. Carlos, M.A.
Licensed Professional Counselor

Consent to Release Medical Information

Name_____**Address**_____

Date of Birth_____**Date of Request**_____

I, the undersigned hereby authorize two way verbal or written communication between: *Theodore Carlos, LPC* **and** _____ **regarding the following information):**

Assessment Results
Clinical Summary / Progress Notes
Statement of Disposition
Any Behavior Contracts / Agreements
Any School/Employment Information or Records

This information is necessary for the following purposes (as applies):

Continuity of Care
Follow-up Treatment
Insurance Verification/authorization

This consent will expire 1 year from the date signed or as otherwise specified by date, event or condition: _____

Signature of client_____**Date**_____

Signature of Parent (if applies)_____**Date**_____

Signature of Witness_____**Date**_____