Bill Jacobs LPCC
Clinical Counselor

(505) 379-0810
bjlpcc@gmail.com

Client Information

(Please print)

Name _____ **Date of birth** _____

Address _____

City _____ **State** _____ **Zip code** _____

Email Address _____

Phones: Cell (____) _____ **Home (____)** _____**Work (____)** _____

May we leave you text messages on your cell phone? Yes ___ No ___

Please indicate where we may leave voice messages: Cell _____ Home _____ Work _____

Gender: M ____ F ____ Married ____ Single ____ Employed ____ Student ____

Occupation _____ **Employer** _____

School_____**Major/Grade** _____

Father's name (if client is under 18) _____ **Phone (____)** _____

Mother's name (if client is under 18) _____ **Phone (____)** _____

Emergency contact name: _____ **Phone (____)** _____

Relationship _____ **Phone (____)** _____

Primary care physician _____ **Phone (____)** _____

Referring provider or other referral source _____

Referring provider's phone (____) _____

When the client's condition is related to an accident, please check below all that apply:

Employment: Current ____ Previous ____

Automobile ____ State in which accident occurred _____

Other accident _____

Insurance Information

Name _____ **Date of birth** _____

Primary insurance company _____

Policy number _____ **Group number** _____

Insured's name _____ **Date of birth** _____

Relationship to client _____

Address _____ **Phone (___)** _____

City _____ **State** _____ **Zip code** _____

Insured's employer _____ **Co-pay** _____

Secondary insurance company _____

Policy number _____ **Group number** _____

Insured's name _____ **Date of birth** _____

Relationship to client _____

Address _____ **Phone (___)** _____

City _____ **State** _____ **Zip code** _____

Insured's employer _____ **Co-pay** _____

Release of Information

I authorize Bill Jacobs LPCC to release appropriate information regarding my treatment to the referring physician or other provider, insurance company, third party paying fees, doctor or any other professional to whom I am referred by the above clinician for continuity of care.

Signature _____ ***Date*** _____

Staff use only

Dx _____ **CPT** _____

Notes _____

Bill Jacobs LPCC

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Albuquerque, NM 87114
505-379-0810
bill@billjacobslpcc.com

Clinical Mental Health Counselor

COUNSELING SERVICE AGREEMENT

Professional Qualifications
I am a Licensed Professional Clinical Counselor in the state of New Mexico. I have a masters degree in counseling from Webster University in St. Louis, Missouri. I adhere to the American Counseling Association code of ethics and the professional standards of the New Mexico State licensing law.

Psychological Services
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings of panic, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Everyone's experience is different; therefore I can make no guarantees.

Sessions
I usually conduct an evaluation that will last from 1 to 4 sessions. During this time we can both decide if I am the best person to help you meet your treatment goals. I typically schedule one session per week, although I see some clients, by agreement, more frequently, and some less.

Private Pay Fees

Type of session	**At time of service**	**With billing**	**With CC**
45-55 minute initial intake	$135	Add $10	Add $10
45 minute individual session	$100	Add $10	Add $10
55 minute individual session	$135	Add $10	Add $10
45 minute couples session	$115	Add $10	Add $10
55 minute couples session	$155	Add $10	Add $10
Court appearances	$250 per hour (including time waiting to testify)		
All other services	$135 per hour		

All private pay and insurance clients must bring a valid credit card to their first appointment and sign an authorization form for its use. I do not accept checks.

Appointments and Cancellations for Medicaid Clients

- If you do not appear for a scheduled session, I will try to contact you by telephone. If I haven't reached you after two attempts, I will put your file on hold until I hear from you. If I don't hear from you in a week, your file will become inactive.

- Medicaid rules prohibit me from charging Medicaid clients for missed sessions with short or no notice. I will, instead, at my discretion, release you back to Medicaid to find another therapist.
- *If you fail to notify me of a cancellation twice in any 6 month period, I will release you back to Medicaid to find another therapist.*
- Since positive therapeutic results depend, to a large degree, on continuity, *if you miss more than 5 sessions for any reason during a 6 month period,* I will ask you to reassess your priorities or release you back to Medicaid to find another therapist. You will need to carefully assess your ability to maintain continuity, once treatment begins.

Appointments and Cancellations for for Private Pay or Insurance Clients

- If you are late for a session, you will be seen for the time remaining in your session, but charged the full rate.
- If you miss a session without canceling, or if you cancel with less than *24 hours notice*, your credit card will be charged for the session you missed at the private pay posted rates.
- If you do not appear for a scheduled session, I will try to contact you. If I haven't reached you after two attempts, I will put your file on hold until I hear from you. If I don't hear from you in a week, your file will become inactive.
- *If you fail to notify me of a cancellation twice in any 6 month period, I will refer you to someone else for treatment.*
- Since positive therapeutic results depend, to a large degree, on continuity, if you miss more than 5 sessions *for any reason* during a 6 month period, I will discharge you or ask you to reassess your priorities. You will need to carefully assess your ability to maintain continuity, once treatment begins.

Billing and Payments
You will be expected to pay for each session at the beginning of the session unless we agree otherwise. If you have not paid your account for more than 60 days and you have not made arrangements for payment, I have the option of using legal means to secure the payment. Unpaid bills may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, I will include its costs in the claim.]

Insurance, Medicaid or Other Third Party Reimbursement
You are responsible for bringing your coverage or Medicaid information with you to your first session if you want me to bill your insurance company for you.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

Insurance and Confidentiality
Should you choose to use health insurance to pay for your services, you should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I offer to you. At the very least I am required to give a clinical diagnosis. Sometimes I am required to provide

additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company database stored in a database. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is out of my hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it. By signing this agreement, you agree that I can provide required information to your carrier.

Limits on Confidentiality

The law protects the privacy of all communications between a client and a counselor. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets specific legal requirements imposed by state law and HIPAA. However, there are some situations where I am permitted or required to disclose information without either your consent or authorization such as situations involving information about child abuse, vulnerable adult abuse, court order, severe threats to health or safety, and worker's compensation. If such a situation arises, I will make every effort to discuss it with you before taking any action thoroughly, and I will limit my disclosure to what is necessary.

Contacting Me

I am not immediately available by telephone when I am in session. However, after hours I am available on a 24-7 basis, most of the time. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact the Agoura Hot Line at (505) 277-3013, or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. Another option is to call your primary care physician or psychiatrist.

Records

You should be aware that, according to HIPAA, I keep protected health information about you in two sets of professional documents. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of how your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history. It can also include any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and reports that I have sent to anyone, including reports to your insurance carrier. Except in unusual circumstances, you may examine and receive a copy of your Clinical Record, if you request it in writing. Exceptions could include: Disclosure could reasonably be expected to cause danger to the life or safety of the client or any other individual; Disclosure could reasonably be expected to lead to the client's identification of the person who provided information to me in confidence under circumstances where confidentiality is appropriate. Because these are professional records, they can be misinterpreted and be upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I charge a copying fee 50 cents per page after that and a $15 administrative fee. I may withhold your Clinical Record until you pay any fees. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

Also, I keep a set of Psychotherapy Notes. These notes are for my use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can

include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that does not require inclusion in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot obtain a copy of your Psychotherapy Notes without your signed, written authorization. Insurance companies cannot require your approval as a condition of coverage nor penalize you in any way for your refusal. You may examine and receive a copy of your Psychotherapy Notes unless I determine that knowledge of the healthcare information would be injurious to your health or the health of another person. I might also prefer to withhold Psychotherapy Notes if doing so could reasonably be expected to lead to your identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate. I would also be obligated to withhold Psychotherapy Notes if they contain information that was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes, or otherwise prohibited by law.

Minors and Parents

Non-emancipated clients under 14 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. Since privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is usually my policy to request an agreement from the parents that they consent to give up access to their child's records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Parental Role in the Therapy of Their Adolescent

A therapeutic relationship with an adolescent can foster positive change. A therapeutic relationship consists of four elements: safety, confidentiality, non-judgment, and affirmation.

Once the free and protected space of the therapeutic relationship is in place, adolescents are inclined to talk freely about their true feelings. If parents cannot tolerate their adolescent talking freely with, or building a safe and trusting relationship with, the therapist, it is better not to begin therapy than damage the adolescent by withdrawing them from treatment before completion. For this reason, I only work with adolescents with a commitment to parental support.

Parents can provide three of the four elements of a therapeutic relationship: safety, confidentiality, and affirmation. The fourth element, non-judgment, is more difficult since boundary setting and evaluation are part of parental responsibility. The therapist does not have to hold the same boundaries or do any direct evaluating, thereby making the relationship easier to develop.

Most adolescents spend the bulk of their time at home and school. It follows, then, that inspection may reveal the cause of an adolescent's difficulty in one or both of those places. At some point, I may wish to talk to people at school about the school environment or to parents about the home environment. Should either of those needs arise, I will need parental cooperation and support to help an adolescent.

Receipt of Service Agreement

By signing my name here I am indicating that I have received this Service Agreement (2c) and agree to it's terms.

Name
(Printed): _____Signature: _____Date:_____

Second Name
(Printed): _____Signature: _____Date:_____

Receipt of HIPAA notice verification
By signing my name here I am indicating that I have received the notice about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of my Protected Health Information (PHI). I understand that this Notice explains HIPAA and its application to my personal health information.
Name
(Please Print): _____Signature: _____Date:_____

Second Name
(Printed): _____Signature: _____Date:_____

Received by: _____Date:_____

Insurance or Other Third Party Billing
By signing my name here I am indicating that I understand that Bill Jacobs LPCC will bill my insurance company or other third-party payer and that I am responsible for any unpaid fees.
Name
(Printed): _____Signature: _____Date:_____

Second Name
(Printed): _____Signature: _____Date:_____

Waiving Parents' Rights to Psychotherapy Notes
My child_____ is under 14 years of age. I realize I have legal right in New Mexico to his or her records. In the interest of my child's success in therapy, I waive my rights to his or her Psychotherapy Notes only, but not to his or her Clinical Record or other documents offered in this agreement.
Name
(Printed): _____Signature: _____Date:_____

Second Name
(Printed): _____Signature: _____Date:_____

Bill Jacobs LPCC

Clinical Mental Health Counselor

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520-203-0179 (fax)
bill@billjacobslpcc.com

Credit Card Payment Authorization Form

Sign and complete this form to authorize Bill Jacobs LPCC to make debit to your credit card listed below for payment of counseling services and appointments.

By signing this form you give us permission to debit your account for our services on or after the indicated date. This is permission for counseling services and scheduled appointments only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Bill Jacobs LPCC to charge my credit card account
(full name)
indicated below for counseling services, appointments, insurance co-pays and missed sessions (without 48-hour cancellation notice) on or after _____ (today's date).
(date)

Billing Address _____ Phone _____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize Bill Jacobs LPCC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____