GENEE FRANCIS, LPC-S, NCC

P.O. BOX 1031 TYRONE, GA 30290 / (P)469.298.8091 / (F)469.277.1280 / GFRANCIS@MAKEUSONECOUNSELING.COM

CLIENT REGISTRATION

Name_____Date of Birth_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Occupation_____

Referral Source: ☐ Insurance Provider ☐ Psychology Today/Internet Search

☐ Physician ☐ Personal Referral by: _____

ASSIGNMENT OF BENEFITS

Check here if other payment arrangements have been made and Genee Francis will not be filing claims on your behalf.

In the event that insurance is filed on my behalf, I hereby authorize Genee Francis, LPC, to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Genee Francis. I certify that the information I have reported regarding my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. My insurance company or I may revoke this authorization at any time in writing. The HIPAA consent form in my file serves as my consent to release any medical information necessary to process this claim.

If insurance information is being provided, a valid insurance card and a valid Government Issued photo ID must be provided. The name on the insurance card must match the name on the ID or proof of any name changes must be provided.

Signature_____ Date_____

ACKNOWLEDGMENT & CONSENT FOR TREATMENT

My signature below indicates that I have received, read, and understand the information explained in the **OFFICE POLICIES** document. I hereby give my authorization and consent for treatment by Genee Francis.

By signing below, I confirm that demographic and biographical information provided is true and correct.

_____

Client Name: Date of Birth:

_____

Signature of Consenting Party: Date:

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OFFICE POLICIES

Qualifications:

I received my Master of Arts degree in Professional Counseling from Argosy University- Dallas. I have obtained a Bachelor of Arts degree from the University of Oklahoma, as well as a Masters in Human Resource Development/Organizational Development from Friends University. I hold licenses in both the State of Texas and the State of Georgia. I received licenses from the Texas Board of Examiners of Licensed Professional Counselors and the Georgia Composite Board of Professional Counselors. I adhere to the rules of the Texas Board of Examiners, the Georgia Composite Board, as well as to the codes of ethics of the American Counseling Association.

Experience:

I have been trained to work with individuals on relationship issues, self-esteem issues, grief/loss, trauma, issues related to college students, and life coaching. My experience has given me the opportunity to work with adolescents, college students, adults, as well as couples in premarital and/or marriage counseling.

Nature of Counseling:

During your treatment, I will make every effort to inform you about the benefits, consequences, or risks of any proposed treatment (or of no treatment at all), alternatives to treatment, and the process of your treatment. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Confidentiality:

Patient records and communications are confidential under provision of the Texas Health and Safety Code, Chapter 611, and other state and federal statutes and rules such as HIPAA. In general, limitations to confidentiality include:

1. You provide consent to release your records or to share information regarding your treatment;
2. You are at risk of imminent serious harm to yourself or others;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases); 7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*If you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. Medical and/or law enforcement officials may be notified with or without your consent.

Couples/Family Therapy:

When seeing couples or families, your therapist will treat as confidential (within the limits cited above) information you disclose that you specifically request not be shared with your partner or family member. However, open communication is encouraged between couples and families, and your therapist may reserve the right to terminate treatment if he/she judges a secret to be detrimental to the therapeutic process.

If a child under the age of consent (younger than 16) is seen, all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.

In cases of separation or divorce, legal documentation (divorce decree or current court orders) regarding conservatorship must be provided before services will be provided to minors.

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Treatment Risks:
As with any treatment, there are risks inherent in psychotherapy. Often therapy exacerbates an emotional state or behavior and a patient can "feel worse before feeling better". Additionally, treatment and patient's resulting growth may have unexpected effects on another person or relationship. During treatment I will make every effort to provide for your well-being through such measures as increasing the frequency of sessions, being available by telephone providing professional coverage if I am unavailable, referring you to another professional as needed, seeking consultation with other professionals, and recommending and helping to arrange for hospitalization if needed. You are urged to contact me and speak openly about adverse effects of your treatment at any time. I do not work with clients whose challenges, in my opinion, are beyond my ability. If this becomes apparent to me at any point, I will discuss this with you, offer you appropriate referrals, and end treatment.

Patient Rights:
Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. Your therapist will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with your therapist are crucial to your success in therapy. You have the right to discontinue your professional relationship with your therapist at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations your therapist makes. If your refusal compromises your therapist's ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), your therapist may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire.

Appointments, Fees & Payments:
Office hours are by appointment only, Monday through Friday.

With the exception of the initial session ($125), fees for 50-minute sessions including individual, marital, and family sessions, and other consultations are $100. Extended session time is pro-rated. Telephone consultations, telephone counseling, and treatment coordination with other professionals will be charged at the normal pro-rated fees. Patients may contact me by telephone for routine questions, scheduling issues, etc., without incurring a fee.

Each patient/responsible party is responsible for fees incurred. Payment is due at the time of service. In order to utilize your time more fruitfully, please have your payment ready at the start of the session. Personal checks, cash, VISA, AMEX, or MasterCard are accepted for payment. Special billing arrangements may be granted on an individual basis and does not cancel your obligation to pay for services received. A fee of $25.00 will be charged for any checks returned for insufficient funds.

If it is necessary to enlist an outside agency or service to collect unpaid charges or handle a bill dispute, the patient/responsible party is responsible for paying the balance due plus late fees plus any collection, legal expenses, or court-ordered fees.

Cancellation Policy: Because your appointment is reserved for you, appointments must be cancelled 24 hours in advance to avoid fees. Same-day cancellations (a "late cancel") will incur a $50 fee and failure to attend a scheduled appointment without cancellation (a "no-show") will incur a $75 fee. Insurance does not cover charges for missed appointments.

Insurance Reimbursement: While I do bill some insurance companies directly there are others that I do not, due to not being an in-network provider. In those instances, at your request, I will provide you with a statement of services which you can then submit to your insurance company for reimbursement. Please be aware that submitting an invoice for reimbursement carries a certain amount of risk, as I cannot control how your information is used once submitted. Not all therapeutic issues are reimbursable; it is your responsibility to verify the specifics of your coverage.

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Service Fees: Other services for which additional fees may apply include: telephone calls, clinical consultations with other providers that you give consent for your therapist to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

Legal Proceedings: Please note that legal proceedings that require your therapist's response will bill at $300 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). **Payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Patient records will not be released without written consent unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Email Policy:
Communication by email should be limited to brief messages and the patient should be aware that email is not secured, and therefore not confidential. Depending on my schedule, emails may not be answered daily but are generally answered within 24 business hours. Lengthy correspondences are available with prior arrangements and are charged at the normal fee. Because it is not possible to guarantee the confidentiality of email communications, please use discretion in deciding whether to communicate with me via email. I cannot be held responsible for any information lost in transit or viewed by a third party.

Vacation or Illness of Therapist:
Arrangements will be made for coverage by a licensed therapist in the event of my prolonged absence. Every effort will be made to notify patients in advance of such an absence and before their scheduled appointment.

EMERGENCIES:
For all mental health emergencies, call 911, the police, or go directly to any emergency room. An additional resource is the Dallas Suicide and Crisis Center hotline (214) 828-1000. DO NOT RELY ON MY IMMEDIATE AVAILIABILITY IN AN EMERGENCY. Take charge of your own or the patient's safety first and foremost. If you or the patient is hospitalized due to a mental health emergency, please notify me as soon as feasible.

Thank you for your attention to the issues raised herein. I look forward to the work that we will accomplish together.

Genee Francis, LPC, NCC

Texas State Board of Examiners of Professional
Counselors 1100 West 49th Street
Austin, Texas 78756

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Consent to Use and Disclose Your Health Information (HIPAA)

This form is an agreement between you, and Genee Francis, LPC. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

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When we consult, evaluate, diagnose, treat, and/or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read this notice and are aware our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information is available to you upon request.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, the new information will be available in our office or you can request a copy by calling us at 469.298.8091.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do accept them, we commit to abide by the limitations that you have requested. After you have signed this consent, you have the right to revoke it by submitting a written request to our Office Manager. Upon receipt of your request, we will discontinue using or sharing your PHI. However, please be advised that we may have already used or shared some of it, and that information cannot be retracted.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

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CREDIT CARD AUTHORIZATION

All appointments must be cancelled 24 hours in advance. Same-day cancellations (a "late cancel") will incur a $50 fee and failure to attend a scheduled appointment without cancellation (a "no-show") will incur a $75 fee that will be automatically charged to your credit card listed below. * This policy is not meant to be punitive, but appointment times you schedule are reserved for you at the exclusion of others who may be waiting to see the therapist.

Checks that are written to Genee Francis that are not honored by your bank for any reason will result in a $25 returned check fee. The credit card below will be charged in the amount of the bounced check and the $25 returned check fee.

Outstanding balances on your account due to co-insurance, deductible, or for any non-covered services (e.g., marital/family counseling, telephone consultations, etc.) for more than 30 days will also be charged to the card listed below. (Payment arrangements are available on outstanding balances by contacting Genee Francis)

All information must be provided

Client Name: _____

Credit Card Type (check one): ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Card Number: _____

Expiration Date (mm/yy): _____ CVC Code: _____

Cardholder Name (as it appears on the card):_____

Billing Address for the Credit Card: _____

City, State, Zip: _____

Email Address:_____ Phone Number:_____

By signing below, I certify that my above information is true, accurate and an authorized user on the account.

I hereby authorize Genee Francis, LPC to keep my signature on file and to charge my credit card account for psychotherapy services and cancellation fees, when applicable. These services can include my participation in individual, couples, family or group psychotherapy, report preparation, telephonic consultation, or consultation services. I also agree to have my above credit card information kept on file and charged for outstanding balances on my account that have not been paid or without payment arrangements made after 30 days.

I understand that if I decide to terminate any of the services and my account is paid in full, I may withdraw the authorization to charge my credit in the future provided I communicate revocation of authorization in writing to Genee Francis, LPC by mail or fax.

Cardholder Signature: _____ Date: _____