Cross Point Counseling
Dannie R. Volek, M.Ed., LPC-S
Intake Information

Please complete this entire form before your first appointment and each time your information changes. All payments are due at the time of service.

Today's Date: _____ / _____ / _____

Part 1: Patient / Client / Demographic Information (Person Receiving Services):

First Name _____ M.I. _____ Last Name_____
Relationship to Insured / Guarantor _____ Sex: M or F
Date of Birth _____ / _____ / _____
Marital Status _____
Address _____ City / State / Zip _____
Home Phone _____ Cell Phone _____
E-Mail:
Employer _____
Current Work Status _____FT _____PT _____Retired _____Student (School: _____)

Part 2: Guarantor Information (Primary Person on Insurance Policy):

First Name _____ M.I. _____ Last Name_____
Relationship to Patient / Client _____ Sex: M or F
Date of Birth _____ / _____ / _____
Marital Status _____
Address _____ City / State / Zip _____
Home Phone _____ Cell Phone _____
E-Mail:
Employer _____
Current Work Status _____FT _____PT _____Retired _____Student (School: _____)

Part 3: Payment/Insurance or Employee Assistance Program (EAP) Information:

_____Private Pay (If checked, insurance information not needed)

Name of Insurance Company _____ (Please Provide Ins. Card to Office)
ID/Subscriber # _____ Group/Plan # _____
Name of Primary Insured: _____
Relationship to patient: ____Self ____Spouse ____Parent

Employee Assistance Program (EAP)Information (Complete if Applicable)
Name of EAP Company _____ Authorization # _____
Number of Sessions Approved _____
Effective Date _____ / _____ / _____ Expiration Date_____ / _____ / _____
EAP Phone # _____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician, psychiatrist, and/or psychologist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

_____You may inform my physician(s) _____ I decline to inform my physician(s)

Physician Name: _____
Clinic: _____
Address: _____
Phone: _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____(Print name of minor)
may participate in counseling sessions with Dannie Volek MEd. LPC-S.
I AM THE PARENT/PRIMARY GUARDIAN OF THE ABOVE NAMED, MINOR AND CONSENT TO HIS/HER PARTICIPATION IN COUNSELING SESSIONS WITH Dannie Volek MEd. LPC-S.

_____ _____
(Printed name of parent/guardian) (Signature of parent/guardian)

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I have read and understand the Notice of Privacy Practices and Client Rights document attached and understand the information provided in its entirety.

_____ _____
(Signature) (Date)

***** ***** ***** ***** ***** ***** ***** ***** ***** ***** ***** *****

REMINDER PREFERENCES: As a courtesy to you, Cross Point Counseling offers a reminder of your future appointments. If you would like to take advantage of this option, please indicate your preferences.

_____ YES, please remind me of my appointment _____ NO thanks, please do not contact me

If yes, please indicate your preferred form of contact:

_____ TEXT MESSAGE: (_____)-_____--_____

Or

_____ PHONE CALL: (_____)-_____--_____

INFORMED CONSENT

Thank you for choosing Dannie Volek of Cross Point Counseling. Today's appointment will take approximately 45-50 minutes. I realized that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws as well as your rights. Please feel free to ask about any other questions or concerns that you may have. I am happy to answer them all. I offer a variety of approaches to counseling. I have over 14 years of combined counseling experience as a school counselor and a Licensed Professional Counselor. I have provided counseling services to individuals, couples, families, groups, children, adolescents, and adults. Because of my personal faith and belief in God my therapeutic approach to counseling has at its core an integration of biblical principles, Cognitive Behavior Therapy, and Person Centered Therapy. These incorporate the person I've become because of my life experiences. I seek to learn what the client wants out of life and then help the client achieve those goals. My role is to listen, teach, and encourage. I believe in meeting people where they are in their life situations/circumstances, then walking along side of them as they work through the process of desired change. Counseling/Therapy is a two way process. The more the client invests in the session and works outside the session, the more progress the client will notice. If you have any questions please feel free to ask.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information necessary for consultation, by information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then, by Texas State Law, I am required to report this to the Department of Family & Protective Services, d) when you sign a release of information to have specific information shared, 3) if you provide information that informs me that you are in danger of harming yourself or others, and/or f) when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call 911 for assistance. I will follow those emergency services with standard counseling and support to the client or the client's family.

FINANCIAL/INSURANCE ISSUES: As a courtesy to my clients I will bill your insurance company, HMO, responsible party or third party payer. I ask that at each session you pay your co-pay or co-insurance that is determined by your personal policy. Payment is collected at the beginning of the session. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. After 60 days, any unpaid balance may be subject to additional fees. In the event that the account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to collect the debt owed.

CANCELLATION POLICY: If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed a $50 cancellation fee. Please understand that I have reserved your appointment time specifically for you, and will need notice of any scheduling changes and/or cancellations, so that I may assist others in their time of need as well. I sincerely appreciate your cooperation. If at any time, you have any questions regarding insurance, fees, balances, or payments, please feel free to ask. You may have a copy of this form, if requested.

Court Appearance/Legal Proceedings: In the event the client, parent/guardian of a minor, legal representative requests my presence at any court proceeding regarding the client, the client/parent/guardian agrees to pay the following fees: $800 per day or part thereof for court attendance and $125 per hour or part thereof for preparation required prior to the court proceedings (minimum of one hour charged). Payment of $925 for the first day of court appearance and the minimum one hour charged for preparation must be made in advance. Charges for additional days and preparation will be billed and due upon receipt after the therapist has been dismissed from the court proceedings. If documents/summaries/or reports are requested for court/legal proceedings, the charge for preparing such documentation will be $125 per hour or part thereof. Payment for the first hour will be due before any documentation is prepared. Charges for additional time if needed will be billed and due upon receipt.

HIPPA NOTICE OF PRIVACY PRACTICES

First and foremost, Cross Point Counseling has been and will always be committed to maintain the client's confidentiality. Healthcare information about you will only be released in accordance with federal laws, state laws, and ethical standards of the counseling profession. This notice describes the policies related to the use and disclosure of your healthcare information.

Reasons for the disclosure of your health information with prior authorization and/or consent: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal law allows me to use and disclose your health information for these reasons:

Treatment: I may need to use or disclose health information about you to provide, manage, or coordinate your care and/or related services.

Payment: I may need to use or disclose information about you to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the primary/guarantor of your insurance policy.

Healthcare Operations: I may need to use information about you to review the treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: 1) Information you and/or your child or children report about physical or sexual abuse: which by Texas State Law, requires us to report this to the Department of Family & Protective Services, 2) If you provide information that informs us that you are in danger of harming yourself or others, 3) Information shared with law enforcement due to a crime that was committed on the premises or against any staff, 4) and/or as a required by Texas State Law.

CLIENT RIGHTS

Right to release your medical records: You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect your medical and/or billing records: You have the right in inspect and obtain a copy of your information contained in the medical records. To request access to your billing or health information, contact Dannie Volek. Under limited circumstances your request to inspect and copy may be denied. If you ask for a copy of any information, a reasonable fee may be charged.

Right to add information or amend your medical records: If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend record. A decision will be made on your request within 90 days. Under certain circumstances, your request to add or amend information may be denied. If denied, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. Your request must be submitted in writing and you must provide an explanation concerning the reason for your request.

Right to an accounting of disclosures: You may request an accounting of any disclosures, if any, I have made related to your medical information, except for information I used for treatment, payment, or health care operational purposes or that I shared with you or your family, or information that you gave me specific consent to release. It also excludes information I was required to release. To receive information regarding disclosures made for a specific time period, no longer than 6 years and after January 2010, please submit your request in writing to Dannie Volek. You will be notified of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information: You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to Dannie Volek. However, I am not required to agree to such a request.

Right to complain: If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy: You have the right to receive any future policy changes secondary to changes secondary to changes in state and federal laws.