Balancing ACT

Life Management Services

Today's date: Clinician: Kimberly Van Buren, LPC-S, LMFT

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Mrs ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No What do you like to be called? Spouse's Name: Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Website ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person / patient here? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Please indicate primary insurance

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Balancing Act] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

History

Please note: information provided on this form is protected as confidential information.

Have you previously received any type of mental health services (psychotherapy, psychiatric services,etc.)?

☐ No ☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ☐ Yes ☐ No
If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No
If yes, please list and provide dates:

_____

_____

Do you have any additional information/ history pertinent to your situation?

_____

_____

Additional Family member's information:

Name of Child(ren): (if applicable)	Age	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Life Management Services
510 Med Court, Ste 106
San Antonio, TX 78258
(210) 326-5292

FEE SCHEDULE AND SESSION AGREEMENT

The laws of the State of Texas indicate the fee and session arrangement must be clearly stated before the first session begins. The information outlined below satisfies that requirement:

1. Our fee per session is $130

2. How many sessions?
   The number of sessions involved depends on many factors. You and your situation are unique. Some idea of the number of sessions that may be involved can only be gained after the initial consultation.

   Problems are not resolved in the office session. Effective resolution depends on how well you transfer what is learned and experienced in the session to real life situations and relationships.

3. Appointments:
   Session Time: A standard session is 60 minutes. Other arrangements can be made in advance, and you will be charged accordingly.

4. Payment of Fees:
   Payment for services is required at each session. Any exception must be approved in advance.

5. Confidentiality:
   Confidentiality is maintained with all counseling sessions. Exceptions to that rule are as follows: If it is determined that you are in danger of hurting yourself, or someone else, if there is evidence of child abuse or elder abuse, for legal proceedings.

6. Testing, Consultations, and Report Writings:
   There will be a fee of $50.00 for any letters, reports, and requests for records, etc.
   To testify or be an expert witness for court proceddings there is a fee of $300.00/hr.
   Pay ment is due prior to services rendered.

7. Termination of Services:
   It is expected that there will be a final session prior to termination of services.

I have read and agree to the above fee schedule and session agreement:

Name_____ **Date**_____

Name_____ **Date**_____

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled.

For cancellations made with less than 24 hour notice or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Notice of Privacy Practices

_____ _____

I have read and understand the Notice of Privacy Practices. Date