Michele V. Ward, MS, LPC

281 456-3688 Office 281 398.1540 Fax

New Client Information Sheet

Name: _____ **Date of Birth:** _____/_____/_____

Name of Parent/Legal Guardian (if minor): _____

Home Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Current School attending (if minor): _____ **Grade** _____

Email Address: _____

Sex: Female ○ **Male** ○ **Marital Status: Single** ○ **Married** ○ **Other** ○

If client is a Minor: Custody (or Guardianship) Agreement in Place? Yes No N/A (Circle one)

RESPONSIBLE PARTY (IF OTHER THAN CLIENT):

Name: _____ **Date of Birth:** _____/_____/_____

Employer: _____ **Occupation:** _____

Home Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Social Security #: _____/_____/_____ **Email Address:** _____

Sex: Female ○ **Male** ○ **Marital Status: Single** ○ **Married** ○ **Other** ○ _____

Reason for referral: _____ **Who referred you?** _____

Previous Therapy/Counseling: _____

Family Physician: _____ **Date of last Physical:** _____

Overall Health: _____ **Chronic Health Conditions:** _____

Current Medications: _____

List names of immediate family members or others living in the home:_____

_____

Neurofeedback Services Agreement

Initial Session includes a thorough symptom review and design of training protocols, tracking mechanisms and identification of baseline data. 60-90 minutes. **Cost of Initial Session $150.00**

Training Sessions are twice a week for between 20- 40 sessions, followed by a reduction in frequency to ensure learning becomes integrated into daily functioning. Each session is 45-60 minutes. The entire process could include as many as 60-80 sessions depending on symptoms, their severity, medications, the consistency of training and the reliability of self reporting. If the symptoms are severe or if the diagnosis is very complex, training could include more than 80 sessions. An evaluation on the number of sessions required can be made after the initial consultation or after the first 10 sessions. **Cost per session $110.00**

Baseline and Interim Testing will be determined at the time of the symptom intake. For people with ADHD/ADD, a Test of Variables of Attention (T.O.V.A.) will be used at the beginning of the first 10 week period and again at the end of the 10 week period. For people with anxiety or depression the Beck's Anxiety (BAI) or Depression Inventory (BDI) will be used. All of these are optional and will be discussed at the beginning of the training period. **Cost per TOVA $125.00 Cost per BDI $30.00 Cost per BAI $30.00**

Other Testing may be required depending on the individual circumstances, particularly in cases in which individuals have a learning disability, are gifted and/or have processing difficulties. In these cases, there will be additional charges for IQ, achievement or other testing. The range of costs for these types of test is between $600-900 per test.

Insurance can sometimes be used to reimburse clients for neurofeedback. We will provide information necessary for the client to complete the appropriate reimbursement forms. Most managed care companies do not cover these services or only partially cover these services. As such, our Neurotherapists are generally not in network and therefore benefits would be based on Out of Network coverage. To determine if Neurofeeback or EEG Biofeedback is a covered item, call your insurance company and ask what your individual "Out of Network" coverage is for the CPT codes listed below. The CPT codes can vary for these services, and so you should ask your insurance company what CPT codes are covered and if there are any deductibles. You should also ask if any authorizations are required. The patient/guardian is responsible for getting any authorizations or pre-certifications with your insurance company prior to treatment. We generally use one of the following CPT codes for reimbursement to the client:

90791	Initial Interview & Consultation
90834/90837	Individual Therapy
90876	**Individual Psychophysiological Therapy including biofeedback by any modality**
90901/90911	**Biofeedback**
96100	Psychological Testing
90889	Report Preparation

Client Name: _____ **Date**_____

Payment Information

Full payment is due at the time of service and clients are responsible for full payment regardless of what their insurance pays as customary fees. Insurance, if filed, is filed by the client not the provider.

Cancellations are required to be made 24 hours in advance. If a cancellation is made without 24 hours notice, the client will be charged the full fee of the session. A deposit or credit card is required to hold the initial appointment and a fee of $110.00 will be charged if the client does not give advance notice of the cancellation or does not show up for the initial session. Once neurofeedback training has started, a credit card will also be required to be kept on file for all charges including those associated with cancellations or "no shows". We will send a statement of charges that are billed to your credit card for any charges to your credit card.

Pre-Payment is an option that will also be discussed at the initial session. Pre-payment of the first (10) ten sessions will result in free baseline testing. The free baseline testing includes T.O.V.A., BDI or BAI. IQ testing is not included as a free baseline test. Pre-payment of the next (10) ten sessions will result in one free interim testing for the client. Payment must be made in advance to receive free testing.

Outstanding balances for (2) two or more unpaid sessions or any fees associated with returned checks will be charged to the client's credit card. For any returned checks the bank fee is $35.00. A credit card must be kept on file for charges associated with neurofeedback or therapy services. A statement and or receipt will be sent to you informing you of the amount and date charges were applied.

I understand and agree to the terms and conditions outlined in this document.

_____ _____

Client or Guardian Signature Date

_____ _____

Therapist Date

Client Name: _____ **Date**_____

Credit Card Information

Master Card ○ Name on Card _____

Visa ○

Credit Card Number _____

Expiration Date _____ Security Code _____

◊ I wish to use this credit card to charge my sessions. **Yes** ○ **No** ○

◊ For the lump sum of the first (10) ten sessions **Yes** ○ **No** ○

◊ I will pay weekly using this credit card. I understand that my credit card will be billed at the end of every week and I will be given a receipt either by mail or at my next visit.
Yes ○ **No** ○

◊ I will pay by check or cash each session. **Yes** ○ **No** ○

I authorize Counseling & Neurofeedback Services to process payments on my credit card as listed in this document.

_____ _____

Card Holder's Signature Date

Michele V. Ward, MS, LPC

281 456-3688 Office 281 398.1540 Fax

Fee Schedule

The undersigned understands and agrees to accept full financial responsibility for all charges. The therapist, if out of network, will collect payment from the client, but will provide all necessary information for client to process insurance. Any returned checks will be processed on the credit card on file and a $35.00 bank fee will be added to the balance. Should the account be referred to an attorney or collection agency for collection, the undersigned client and/or client's guarantor will be responsible for actual attorney fees and/or collection expenses.

The fee for your initial session is $ 150.00. The fee for each talk therapy session thereafter is $130.00. The fee for each neurofeedback, biofeedback or other therapy session is $110.00. Fees for testing services are listed under the neurofeedback agreement or in a separate document.

Additional time may be charged accordingly. Phone consultations, forms, and letters lasting in excess of 15 minutes or more may be charged accordingly.

Expires 12/31/17

I have read and agree to the payment policy and fee schedule.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Guarantor/Guardian (if a minor) **Date**

_____ _____

Signature of Therapist **Date**

Statement of Understanding

This information is provided to you to help you better utilize psychotherapy services.

PRIVACY/CONFIDENTIALITY

If you need any of your information to be released your written permission is required by law. In addition, state law requires that any mental health professional is responsible for reporting to appropriate parties' instances when a person is a danger to him or herself, to others, or when a child or vulnerable adult is involved in abuse and/or neglect.

RIGHTS AND RESPONSIBILITIES

You have the right to refuse treatment. Even though your therapist may make certain recommendations, you may choose not to follow the therapist's advice. Should you refuse treatment, you will be apprised of consequences that may result from you refusal; alternatives may be available. You have the right to know the assessment of your problem, the recommended treatment and any resources available to support you.

Along with these rights go certain responsibilities:

- **To be honest, open and willing to share your concerns with your therapist.**
- **To ask question when you do not understand or need clarification.**
- **To follow the treatment plan agreed upon and to discuss any reservations you may have about your treatment goals.**
- **To keep appointments or to call with in 24 hours prior to your appointment, otherwise you will be charged for that session.**

FEES

Please be sure that you have read and understand the Fee Statement Policy. You assume financial responsibility for such services.

_____ _____

Signature **Date**

Client Name: _____ **Date**_____

NOTICE OF PRIVACY PRACTICES

This Notice describes how psychological and health information about you may be used and disclosed and how you can get access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges receipt of these documents and acceptance of the conditions of the privacy policies of Michele V. Ward, MS, LPC.

_____ _____
Patient **Date**

_____ _____
Parent or Guardian **Date**