PATHWAYS CHRISTIAN COUNSELING

1707 San Jacinto
Dallas, TX 75201

Client Information

Client Name: _____ Date of Birth:_____ Age: _____
Last First MI

__Male __ Female __ Married __ Single __ College __ Child

Phone (Home): _____ (Cell): _____ (Email): _____
Please include area codes

Home Address: _____

City _____State _____Zip Code _____

May we mail correspondence to your home address? _____

Place of Employment: _____ May we call?_____ Phone: _____

Best Time(s) to call: _____ Who referred you? _____

Who may we contact in case of emergency? _____ Phone: _____

Fees: We offer a sliding scale to assist individuals and families in need of counseling. Payment is requested at the time of the sessions. We accept checks, cash, and credit card. For individuals and families unable to pay the fee at each session, please discuss your difficulty with the counselor to discuss a payment plan.	Fee- $100.00 per 50-60 minute session for individuals
Insurance: If you're on a managed care plan that requires pre-certification, please contact your insurance provider to determine if your counselor is a network provider and to verify benefits. If you have traditional insurance, we can provide you with a receipt upon request so that you may file for reimbursement.	
Cancellation of Appointments: Due to scheduling demands, we require 24-hour notice to cancel a session. Otherwise you may be charged for the session. We understand there can be emergencies that will prevent you from giving appropriate notice. In these cases, your counselor may not require payment. **INITIALS:_____**	

CLIENT'S INFORMED CONSENT

I understand that during counseling, issues may be discussed that could be upsetting in nature and that this may be necessary to help me resolve my problems. I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults. I understand that state and local laws require that my therapist report all cases in which there exists a danger to others or myself. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand if I have a managed care insurance plan that offers reimbursement to Pathways Counseling Center, I must indicate that at the time I complete my initial paperwork, and call my insurance company to authorize sessions to cover therapy. If I have traditional insurance, understand it is my responsibility to file for reimbursement Pathways Counseling Center will supply a receipt that will have the necessary information needed to process the claim. I agree to pay my counseling fees as arranged at the time of my first session in a timely manner. Should a third party other than insurance agree to pay for my sessions, I agree to allow Pathways Counseling Center to release billing information to the third party.

I have read and understand the above conditions of my treatment and agree to their content.

Signature: _____ Date: _____